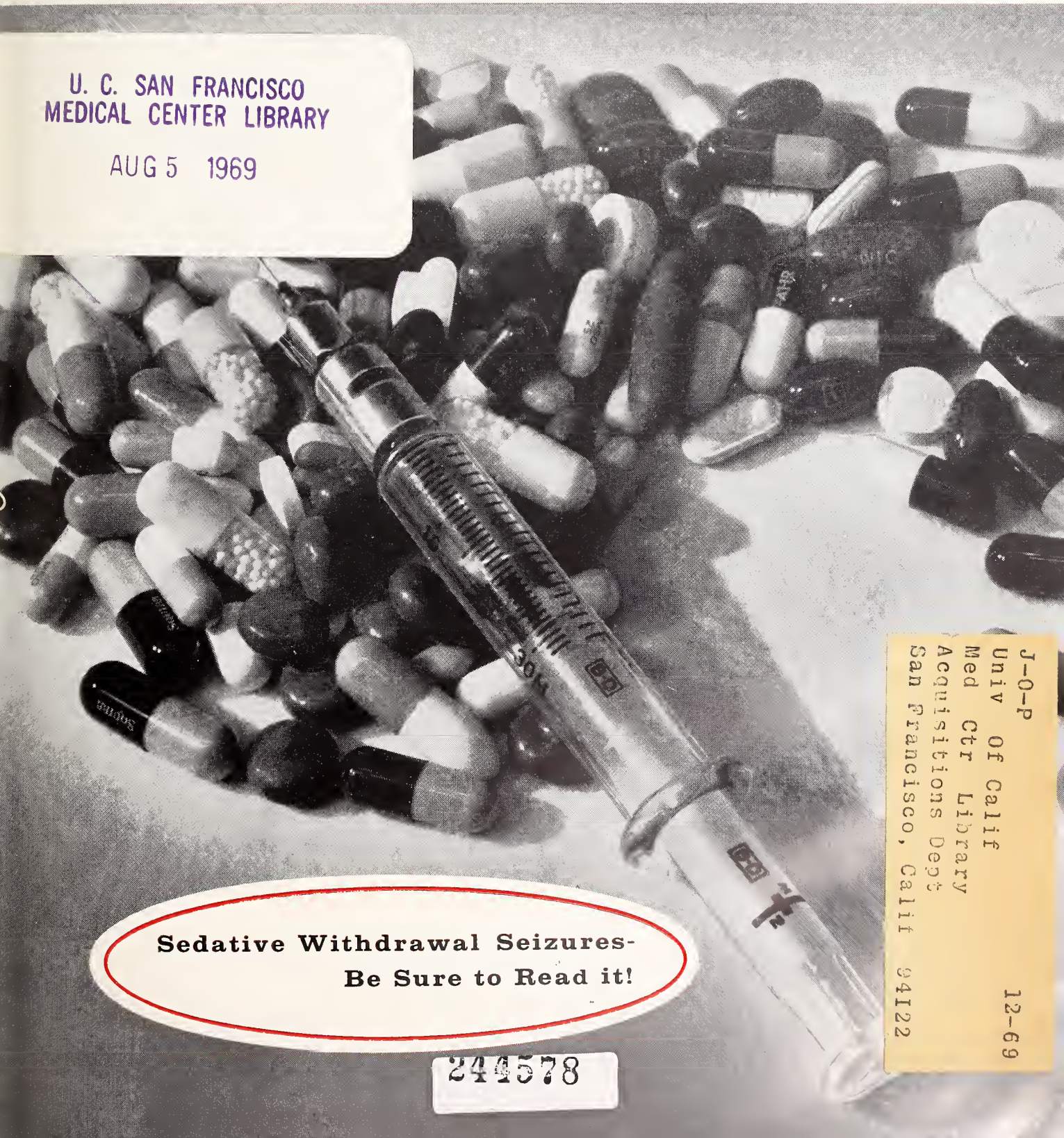
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The JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION

July, 1969 Vol. 62 • No. 7
Indianapolis, Indiana

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(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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Contents

SCIENTIFIC

Sedative Withdrawal Seizures, Wesley A. Kissel, M.D., Indianapolis 793

Goodpasture's Syndrome in the Elderly, (Report of a Case), Alden T. Schmidt, M.D., Ella Sternberg, M.D., South Bend 796

The Cryoextraction of Cataracts, A Comparative Study with Conventional Instruments, David L. Alvis, M.D., George A. Clark, M.D., Richard B. Rich, M.D., Indianapolis .. 801

The Case of the Rocky Ripples, Arnold Lieberman, M.D., New York, N.Y. 804

Electrocardiogram of the Month: Q Waves in Idiopathic Hypertrophic Subaortic Stenosis, Charles Fisch, M.D., Indianapolis 808

X-Ray Conference: Traumatic Arteriovenous Fistulae of the Kidney, Erich K. Lang, M.D., Reed A. Fontenot, M.D., Bendel Johnson, M.D., Raymond W. Turner, M.D., Eugene St. Martin, M.D., Shreveport, La. 810

Path-finder: Renal Function Tests 817

EDITORIALS

Uniform Anatomical Gift Law 819

The Ultimate Tranquilizer (Guest) 819

Editorial Notes 820

SPECIAL FEATURES

Scientific Exhibit Application Form 809

Convention Art, Hobby Show Application Form 826

REGULAR FEATURES

President's Page 777

Month in Washington 778

Fourth Estate 786

What's New? 791

The Woman's Auxiliary Reports to ISMA 823

Gleaned from the British Medical Journal, Jack W. Hickman, M.D., Indianapolis 827

Medical Panorama: It Might Happen Here, A. W. Cavins, M.D., Terre Haute 828

Wanted: Physicians, Locations 829

Your Indiana Blue Shield Board of Directors (One of a Series) 830

Medicine At Law 831

Board of Health Report 835

Abstracts, Book Reviews 839

From The Journal 50 Years Ago 842

News Notes 847

Annual Meeting Dates of Professional Medical and Allied Organizations 857

Future Meetings, Seminars, Courses 858

County, District News 859

Deaths 860

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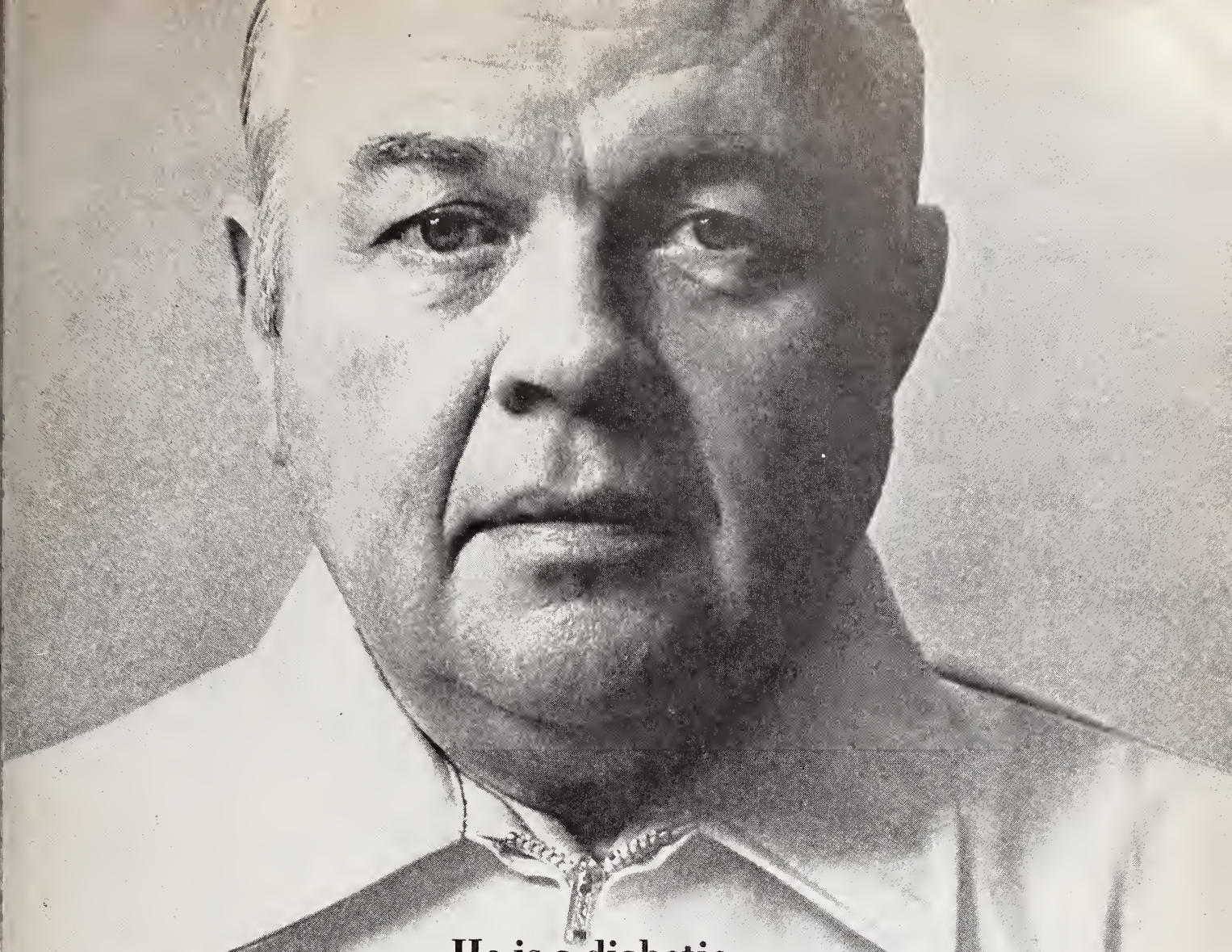
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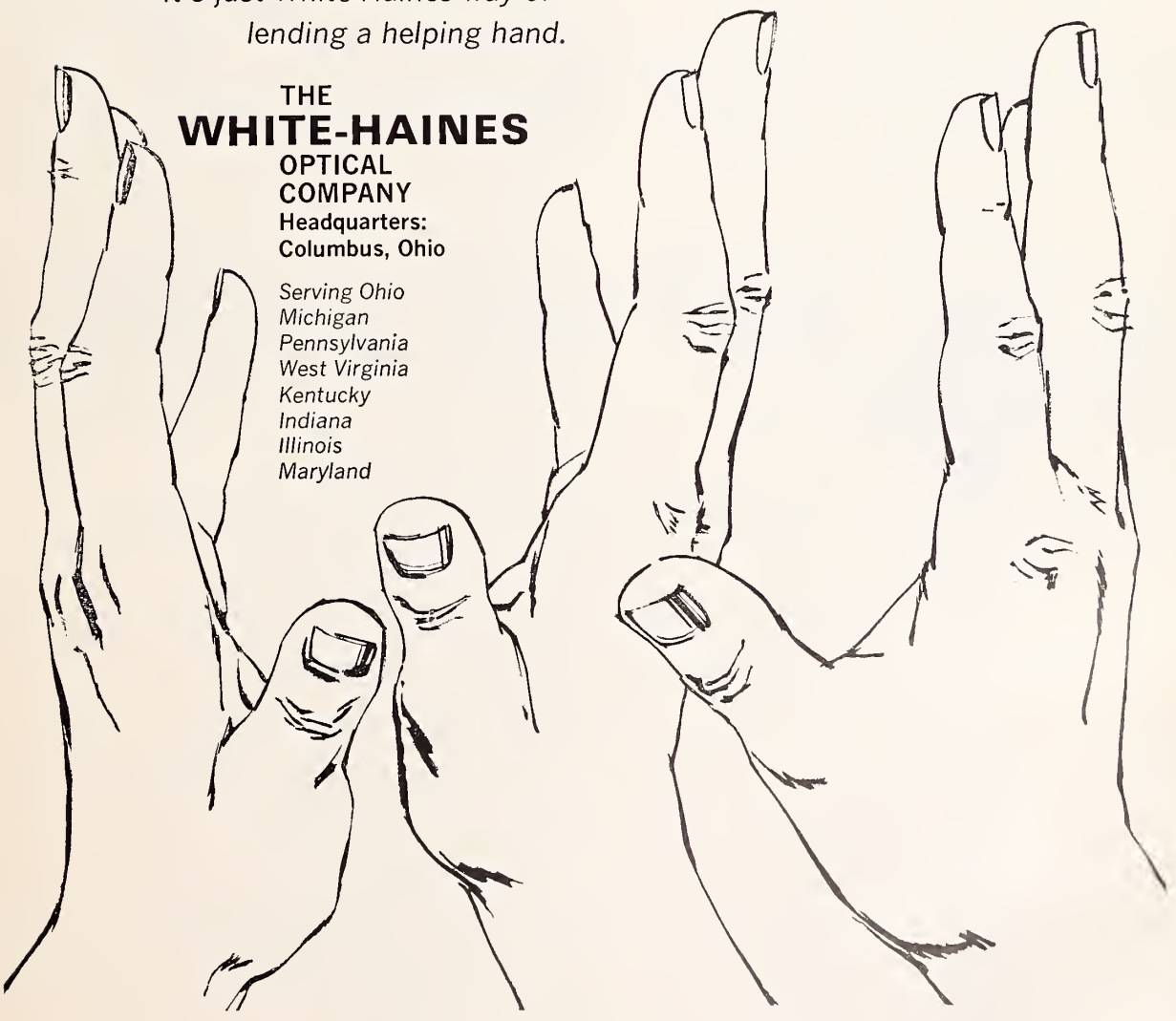
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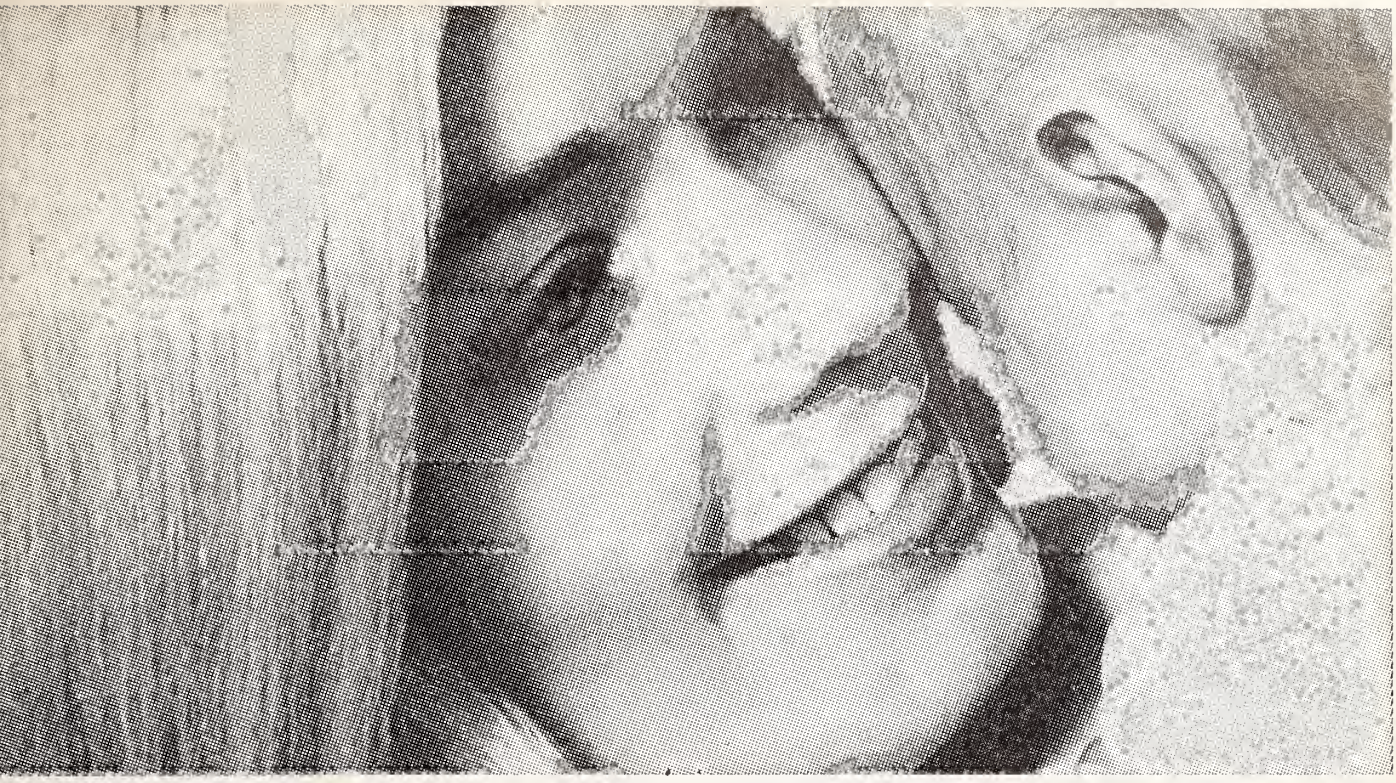


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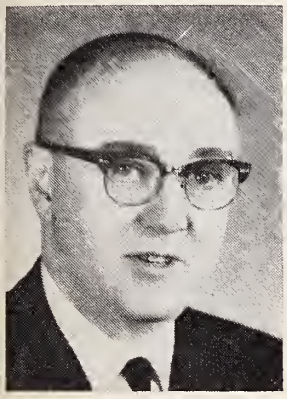
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President's Page

Integrity—Keep It Visible

The practice of medicine has remained notably free of restrictive regulations from outside its own ranks. We are probably the most prominent provider of vital services to the public which yet retains this freedom.

Contrast this with the numerous and increasing agency controls over communications, transportation, power utilities, financial institutions, and consumer goods suppliers. Other public services such as education, public safety, highways and postal services are largely governmental functions.



Presently, our self-discipline is in our own hands—directly, by our peer committees, hospital staff mechanisms, and our professional societies, and —indirectly—by means of licensing boards and governmental agencies, which are usually composed of professionals.

We can expect demands for drastic changes in this pattern unless we give highly visible evidence of our sincerity and our ability to establish and maintain impeccable ethics and performance.

It is imperative that we constantly demonstrate our desire and our competence to maintain standards of performance in delivering high quality health care within the framework of desirable social and economic goals.

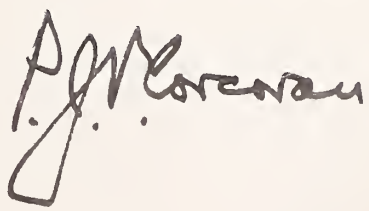
The current clamor of criticism relating to medicare and medicaid must be evaluated promptly and fairly on the basis of the facts. We should take adequate measures to correct any deficiencies or abuses which might be found. We should develop techniques to prevent recurrences and to avoid any other prospective criticisms. Means of detecting problems early and of forestalling future defects must be devised.

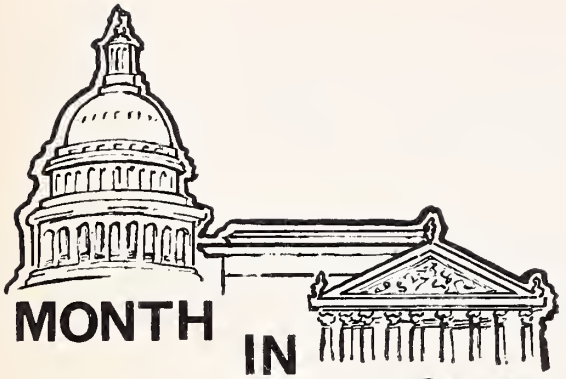
The public and our patients should not have to ask us to do this. Moreover, our own self-interest compels it. The standards we espouse should be the highest attainable; the compliance we exact must be unquestionable.

Maintaining the quality of our membership requires active, ongoing monitoring. Suitable prophylactic measures can prevent the subsequent need for more difficult therapeutic, often traumatic, steps. We are prone to delay in a laissez faire mood, instead of taking the initiative which would really save time and trouble.

A local medical society should have a professional standards committee, appointed for the internal "quality control" of its membership. It would be distinct from a grievance committee, which deals separately with problems external to the society. Any actual discipline in overt problems should be administered by the elected officers designated for this.

A professional standards committee, for its part, would be entrusted with the responsibility of quietly and confidentially inquiring into any matter which potentially threatens the good name of a member or of the profession. It could avoid the untimely delay which is caused by waiting for written charges to be filed against the member, for by then it is often too late to achieve maximum good. As a committee, it can deal impersonally with matters that might be intolerably embarrassing for an individual to attempt to do for a colleague. I offer this to you for consideration and possible adaptation to your own locality.





MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

WASHINGTON, D.C.—The American Medical Association has offered to cooperate in a Senate investigation of large medicare and medicaid payments to physicians and other health practitioners.

THE OFFER followed a Senate speech by Sen. John J. Williams, (R., Del.), in which he reported that the staff of the Senate Finance Committee had found that several thousand doctors, dentists and others had received $25,000 or more for their services under the two government programs in 1968.

IN A SECOND Senate speech, Williams expressed appreciation for the AMA offer to cooperate.

"THIS IS THE TYPE of cooperation we need, and I appreciate this support from the American Medical Association," Williams told the Senate. "I sincerely hope that we shall have similar pledges of support from representatives of the other groups affected.

"I CAN ASSURE EACH of these groups that our study will not result in a blanket indictment against any segment of the industry involved. We fully recognize that the overwhelming percentage of those who are in any way connected or working with this program are trying to do a good job; however, when instances of exploitation or excessive charges are discovered they must be exposed and properly dealt with."

WILLIAMS, who has announced he will not seek re-election next year, is a member of the Senate Finance Committee which is making an extensive study of the operation of medicaid and medicare.

WILLIAMS SAID THAT, although a staff report would not be ready until later this summer, the committee's investigation already had shown:—

"FIRST, in 1968 the medicare program paid $25,000 or more to each of at least 5,000 physicians.

"SECOND, thousands of health practitioners—doctors, dentists, optometrists, and others—were each paid $25,000 or more under the welfare health care programs in 1968 . . . . A surprising note is the large number of dentists appearing on the lists from welfare agencies . . . .

"DATA HAS also been gathered and detailed tables prepared comparing the average medicare payments for the most common surgical procedures for older people with the maximum payments allowed under the most widely held Blue Shield contract in the same

geographical area.

"THE RESULTS are startling. Medicare's average payments run as much as two to four times as high as Blue Shield maximums. For example, in two areas of the country, medicare's average payment for a cataract operation is more than four times as much as the Blue Shield allowance. These are not isolated cases. There is a pronounced pattern of inflated payments by medicare.

"THE REPORT to the committee will include pinpointing the causes underlying these extremely generous handouts of public funds.

"ANOTHER UNUSUAL situation has occurred in Social Security's pressing carriers to pay for so-called supervisory services rendered by a teaching physician even though the actual care is provided by an intern or resident. Before medicare virtually no insurer paid for such services . . . .

"THE INVESTIGATION has expanded the evaluation of carrier and intermediary performance to determine whether the government is getting what it is certainly paying for and the extent to which intermediaries and carriers are carrying out specific functions assigned to them by the medicare statute.

"THUS FAR a wide variance and level of performance has been observed . . . .

"THE LAW REQUIRES intermediaries and carriers to exercise effective controls on utilization of services . . . .

"YET SOME CARRIERS and intermediaries appear virtually to ignore performance of this vital function while others seem to be doing a reasonably effective job."

FOLLOWING Williams' first speech, the AMA issued a statement saying that it shared with the senator a concern over the rising costs of medicare and medicaid. The association offered to cooperate with the Senate Finance Committee or any other congressional committee studying the problem of rising health care costs. The AMA earlier had made the same offer to Health, Education and Welfare Secretary Robert H. Finch.

THE AMA STATEMENT said:—

"FOR SOME TIME the AMA has been giving national leadership in coordinating the efforts of state and county medical societies in the establishment and effective functioning of local review and utilization committees checking on the health care services rendered under the medicare and medicaid programs. Close liaison also has been established between carriers and many medical societies in reviewing disbursements under the government programs.

"ALL INVESTIGATIONS so far have indicated that an overwhelming majority of physicians participating in medicare and medicaid are charging reasonable fees. The charges of only about two percent of the physicians receiving payments from the programs have been challenged. Of course, the AMA favors appropriate action in any of the cases where physicians are found to receive improper payments. Last June, the AMA Board of Trustees urged all state and local medical societies 'to act swiftly and firmly in all instances of known exploitation, and excessive charges for health care that may occur in their jurisdiction.' In 1967, the AMA said

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'any reports of abuses by physicians or by any other health care program should be thoroughly and promptly investigated and action taken where indicated.' Several medical societies have expelled members where it has been proved that a physician's charges were excessive or he in some other way exploited the program.

"THE AMA, through its publications and speeches by its officials, has been emphasizing to physicians the responsibility they have to hold down the health care costs of their patients both under and outside government programs. In an April 17 letter to Finch, Dr. Wilbur said the AMA 'is eager to make available to your office the composite experience and judgment of the nation's physicians, who are the principal providers of health care to all the people.'

"THE KNOWLEDGE and judgment of the nation's physicians—as well as of the prepayment plans, health insurance industry, hospitals, the allied health professions, the actuaries and others—must be enlisted in your battle against the health-care portion of the inflation problem," Dr. Wilbur said.

HOUSE PASSES EXTENSION OF HILL-BURTON ACT

THE HOUSE PASSED and sent to the Senate a three-year $937 million extension of the Hill-Burton Act under which the federal government has helped finance construction of hospitals and nursing homes with 425,000 beds.

MEMBERS APPROVED the measure on a 351 to 0 roll call after turning down a series of amendments designed to channel the matching hospital grants more into big cities than urban areas and into modernization rather than new hospital construction.

IN ADDITION TO extending existing aid, the bill provides new loan guarantees, as requested by the Nixon Administration, and interest subsidies, which the Administration opposed.

THE BILL AS PASSED authorizes appropriations (over three years) up to $405 million for hospital construction; $165 million for modernization; and $300 million in guaranteed loans, toward which the government would contribute up to $37 million in three percent interest subsidies. In addition, grants up to $30 million could be made for emergency room modernization.

AMA URGES SUPPORT FOR MEDICAL EDUCATION

THE AMERICAN Medical Association urged that Congress approve full appropriations for medical education programs.

DR. C. H. WILLIAM RUHE, director of the AMA's Division of Medical Education, testified before a House appropriations subcommittee that the nation's urgent need for more physicians could "only be met effectively by a major increase in the capacity of American medical schools to educate more physicians."

"IT IS THEREFORE appropriate to emphasize again that full funding in the amounts authorized by the Health Manpower Act of 1968 is necessary to permit the construction of new and expanded

Continued on page 785.



The burdened heart...

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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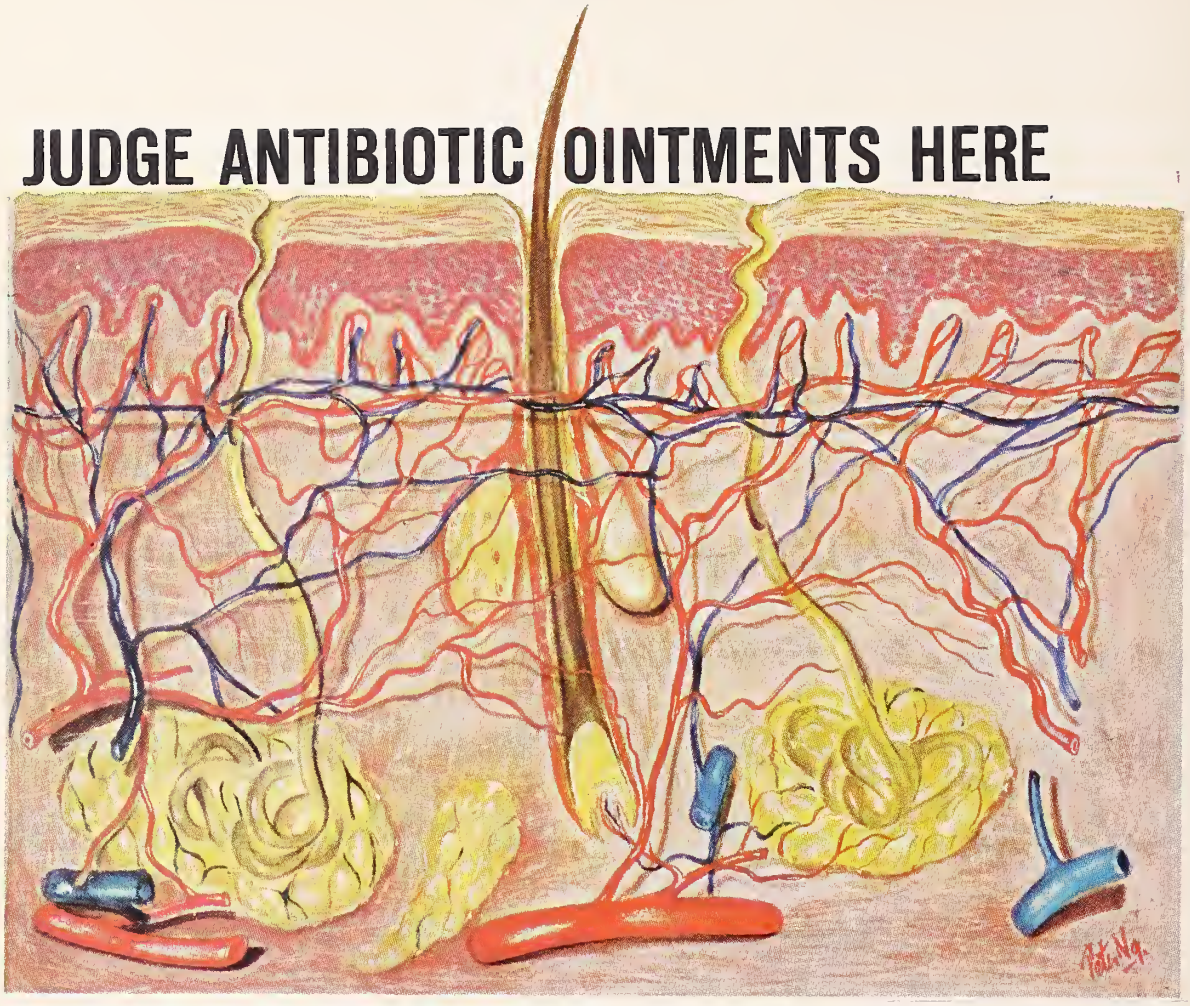
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Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

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Continued

facilities before major enrollment increases will be feasible," Dr. Ruhe said.

IN A LETTER to the House Public Health and Welfare Subcommittee, the AMA also supported extension of the Medical Library Assistance Act. Dr. Ernest B. Howard, AMA executive vice-president, said that "we cannot exaggerate the importance to the health professions and the public they serve" of the many beneficial services supported through the programs.

PRESIDENT APPOINTS COUNCIL ON AIR POLLUTION

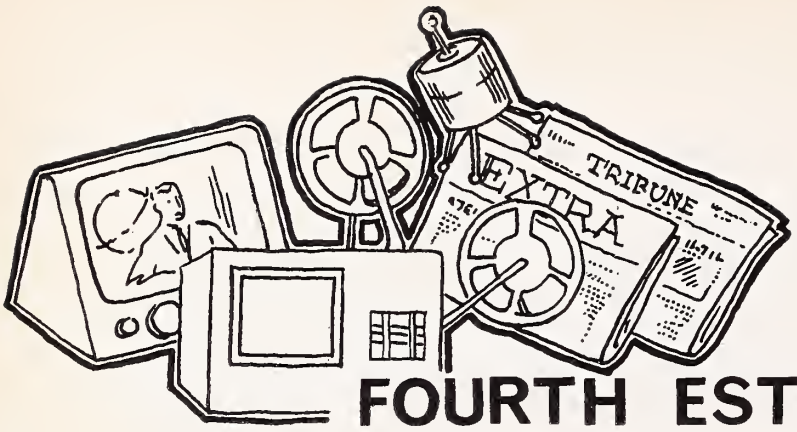
PRESIDENT NIXON created the cabinet-level Environmental Quality Council to begin a major attack on pollution of the environment. He also named a companion 15-member Citizens' Advisory Committee on the recommendations of Lee A. Dubridge, Ph.D., his chief science adviser.

THE PRESIDENT SAID the council, serving as an advisory board on a par with the National Security Council and the Urban Affairs Council, "will provide the focal point for this Administration's efforts to protect all of our natural resources."

DUBRIDGE SAID "the problem is how we can make maximum use of our environment . . . without despoiling it." He said the council would move promptly on the problems of disposal of waste products —a key factor in deterioration of the environment.

THE PRESIDENT will head the council, which also will include the Vice-President and the Secretaries of Agriculture, Commerce, Health, Education and Welfare, Housing and Urban Development and Interior and Transportation.

LAURENCE S. ROCKEFELLER, one of the nation's leading conservationists and a key figure in Lady Bird Johnson's National Beautification campaign, will be chairman of the Citizens' Advisory Committee. ◄



FOURTH ESTATE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Genetics

Most people remember the term, "genetics," as an explanation by a high school biology teacher of how people with blue eyes can sometimes have babies with brown eyes.

But to the 644 Hoosiers who were referred to the Medical Center of Indiana University at Indianapolis last year, a genetic explanation was a matter of compelling, even mortal, urgency.

For some, it meant finding a genetically compatible donor for a kidney transplant which would have a maximum chance of success.

For others, the parents whose first born child was mongoloid, it meant learning the risks of future pregnancies. Often, these parents learned that there is no special risk that the tragedy of mongolism would be repeated.

For many of these 644 Hoosiers, genetics meant a diagnosis of one of the several thousands of usually rare, invariably complex, inherited diseases which could be diagnosed nowhere else in Indiana.

The reason is that the medical genetic diagnostic techniques are nearly as complicated as the diseases themselves.

The 644 patients who were referred to the medical genetics services of the IUI Medical Center required 8,352 separate laboratory tests for themselves and for members of their families (the clues for a genetic diagnosis often lie in the patients' relatives).

Many of these tests were used in the genetic counseling service of the Department of Medical Genetics.

Not all genetic diseases are inherited, at least not in the usual sense.

Defects in genes can be family traits which persist for generations. Or, the defects can be caused by certain drugs, by radiation, and even by the process of aging.

There are genetic diseases—mongolism, for example—in which only laboratory tests can determine whether the genetic fault is a permanent and persistent family trait or an accident of mutation which will not persist in the family line.

For the parents of a mongoloid child, these tests offer the knowledge of whether any future children would be blighted or normal. For these parents, this knowledge is imperative.

For the patient who needs a transplanted kidney, the necessary preliminaries may include genetic studies of many of his relatives and of many other potential donors.

Unless he has an identical twin, an individual's genetic composition is as unique as his fingerprints. The problem in organ transplants is to match the genetic composition of the patient and the donor as closely as possible: the closer the match, the less the risk that the transplanted organ will be rejected.

This makes the medical geneticists at the IUI Medical Center exceptionally important members of the kidney transplant team.

There is more than meets the eye when blue-eyed parents have brown-eyed babies.—*Decatur Democrat*, April 26, 1969.

Getting Enough Doctors

An Indiana University medical professor, Dr. Jack W. Hickman, has the answer to the frequently-asked question: What's happened to all of the family doctors?

The assistant dean at the IU Medical School points out that where Indiana graduated 209 doctors from medical school last year, Indiana hospitals were offering residencies in specialties to 427 physicians.

The implication is that specialties are taking twice as many doctors as are produced each year. This is not statistically possible. But the drain is unmistakable with the appeal of specialties taking most of the newly-graduated doctors plus reaching into ranks of practicing generalists to convert them into specialists. Even so, many opportunities to study specialties still go begging.

Nationally, the story is much the same, with 10,000 residencies in specialties seeking the 8,600 young doctors graduated each year from the country's medical schools.

At least, one would assume that there finally would be an adequate supply of specialists, if not of general practitioners. But this is not the case. Specialists tend to bunch up

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near the training centers and specialized facilities that produced them, having a shortage of their numbers elsewhere across the country.

Some specialties, even, are in short supply. These include dermatology, ophthalmology and urology which have failed to attract such numbers as have surgery, obstetrics and gynecology, internal medicine and radiology.

There obviously is need to increase the production and supply of doctors of all kinds, but there will remain the necessity to find ways, also, to spread out any increased supply geographically, and across the spectrum of medical practice. Increased numbers alone will not suffice.

It will take much more in the way of creative approaches and attractions to assure the wide and general sufficiency of medical service.—*Lafayette Journal & Courier*, May 7, 1969.

Biomedicine Marches Ahead!

Within the last decade, the medical school of Indiana University has improved its image to such an extent that the Hoosier taxpayer of today has every right to be proud of his institution. About ten years ago, the biomedical professionals at Indianapolis, realizing the medical profession's dependency on biomedical and paramedical personnel, technology and research, foresaw the time when they would be at least as important as their colleagues on the Bloomington campus who have been honored by membership in the society of the Sigma Xi. Last Friday, their vision became reality during formal ceremonies held in the school's Emerson Hall, culminating in the presentation of the charter to the Indiana University Medical Center as a separate chapter of the honorary scientific society.

The significance and the role of Sigma Xi in today's academic world was stressed by Dr. Francis C. Croxton, the society's president-elect. He recalled that the 1886 motto "Partners in Investigation" was considered inadequate and was changed to "Companions in Zealous Research" in 1892. Today, more than ever in the past, this motto is a pertinent reminder of the fact that the scholar is no longer entitled to refer to "his" work, "his" research, or "his" findings. Teamwork prevails on the university campuses and teams in a given field cooperate with those in allied fields in the search for answers to questions the human mind is capable of posing.

The biomedical scientists are by themselves companions in zealous research, but they have also become sought-out companions of the members of the medical profession whose armamentarium and techniques originate in the biomedical field. Sigma Xi furthers interdisciplinary relationships and acts as a catalyst in blending various disciplines.

A Sigma Xi chapter at a medical school is destined to advance the limit of knowledge of all members of the institution. It influences and encourages research on the campus and on those of other medical schools. It contributes to the ability to investigate, understand and interpret the facts of nature in the various branches of modern science.

Biomedicine will continue to march ahead at our Indiana University Medical Center.—Editorial, Radio Station WMRI, Marion, Ind.

The Doctor Shortage

There are 310,000 physicians in the United States, with fewer than 280,000 directly involved in patient care, according to Dr. Richard M. Magraw, deputy assistant secretary for health manpower in the Department of Health, Education and Welfare. The other 30,000 work in research and health and hospital administration.

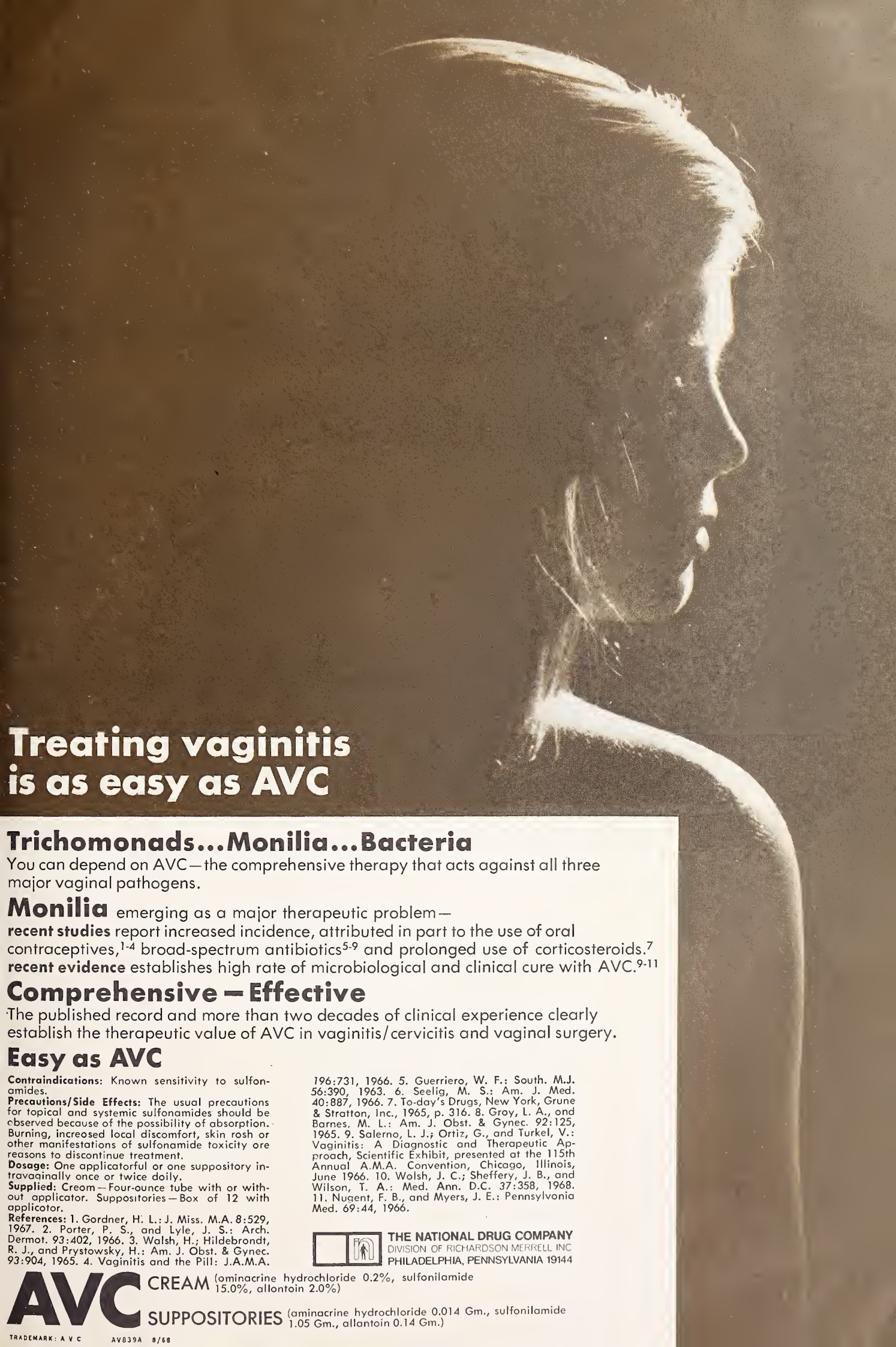
The 280,000 practicing physicians average out at one for every 750 persons in the nation (on the basis of an estimated 210 million population.) But with so many in specialties, the average of general or family physicians, who are available for all occasions, is much smaller.

The truth is that there is a shortage of 50,000 physicians in America today. An American Medical Association survey in 1967 showed five counties in Colorado with 2000 to 5000 people with no physician at all, a fifth of the county seats in Illinois with no physician and a Southern Illinois county of 10,500 with only one physician.

There are 99 medical schools in the country and 105 expected by 1970. The schools graduate an average of under 100 each, a total of 7973 last year. The need is immediate. Therefore, the government offers medical schools bonuses for training physicians and loans to graduate physicians to work in rural areas, where they are so badly needed.

A young man who can qualify and wants to do a needed, human public service, and at the same time be very well compensated, can do no better than choose the practice of medicine. —*Logansport Pharos-Tribune & Press*, May 14, 1969. ◄





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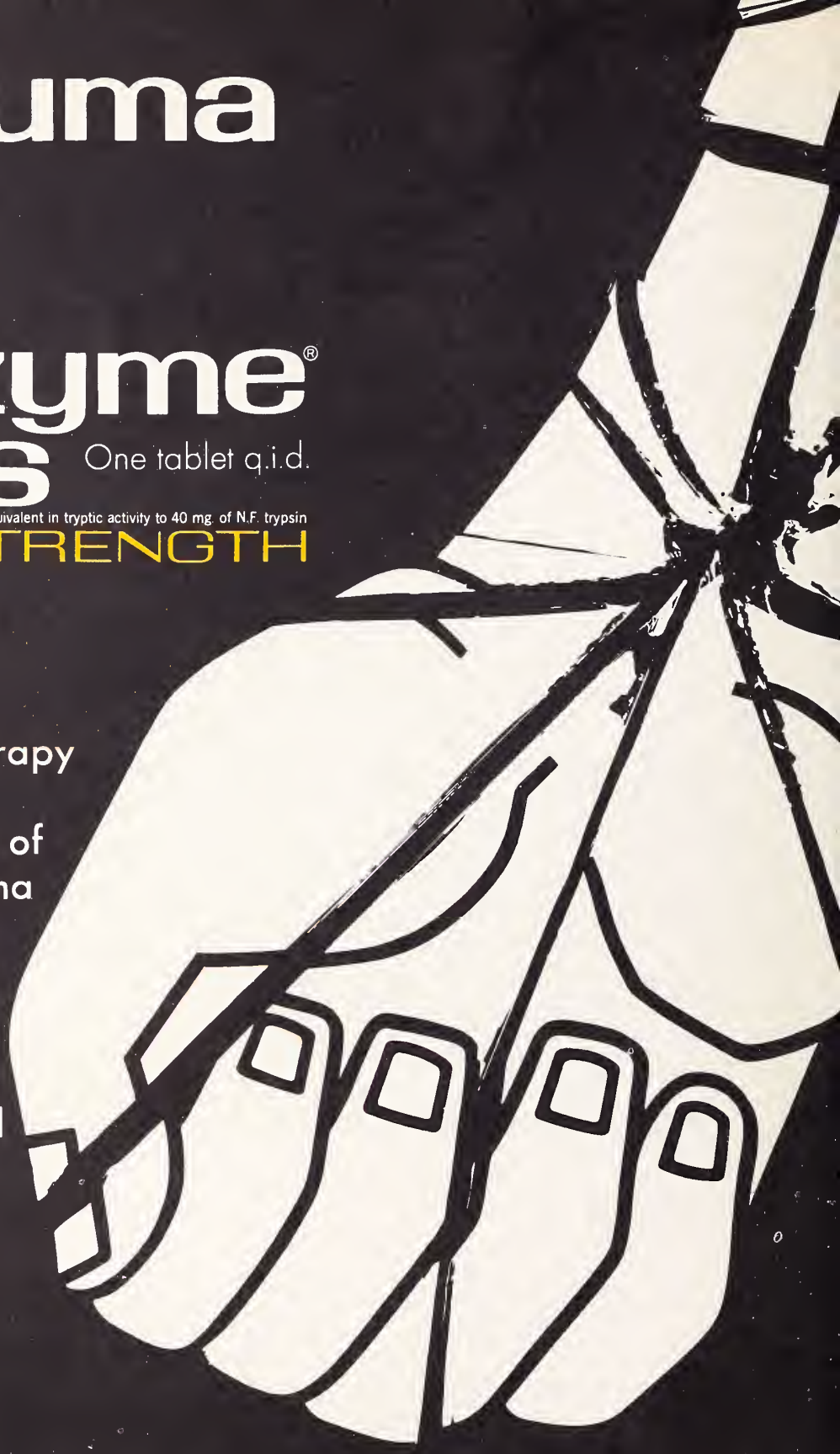
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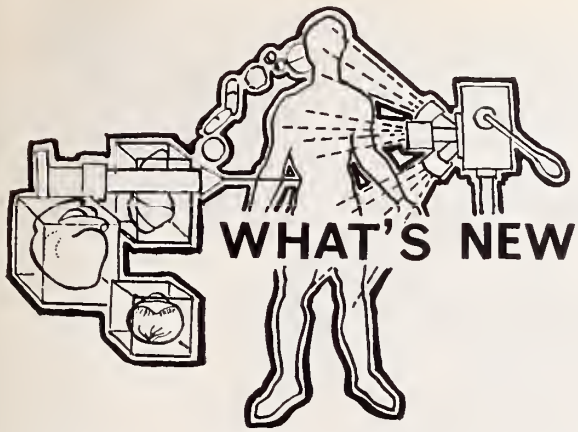
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Eli Lilly has announced the availability of another of the cephalosporin family of antibiotics. The new agent, Loridine™ (cephaloridine) is chemically close to Keflin® (sodium cephalothin) and differs only in the substitution of a pyridine ring for an acetate radical. Important clinical differences have been demonstrated. Loridine is practically painless when given intramuscularly. It should not be used in the presence of low kidney function, and is recommended for use only when a pathogen's sensitivity to it has been demonstrated. It is not thought to be suitable for initial therapy. Doses up to 4 grams daily are considered safe.

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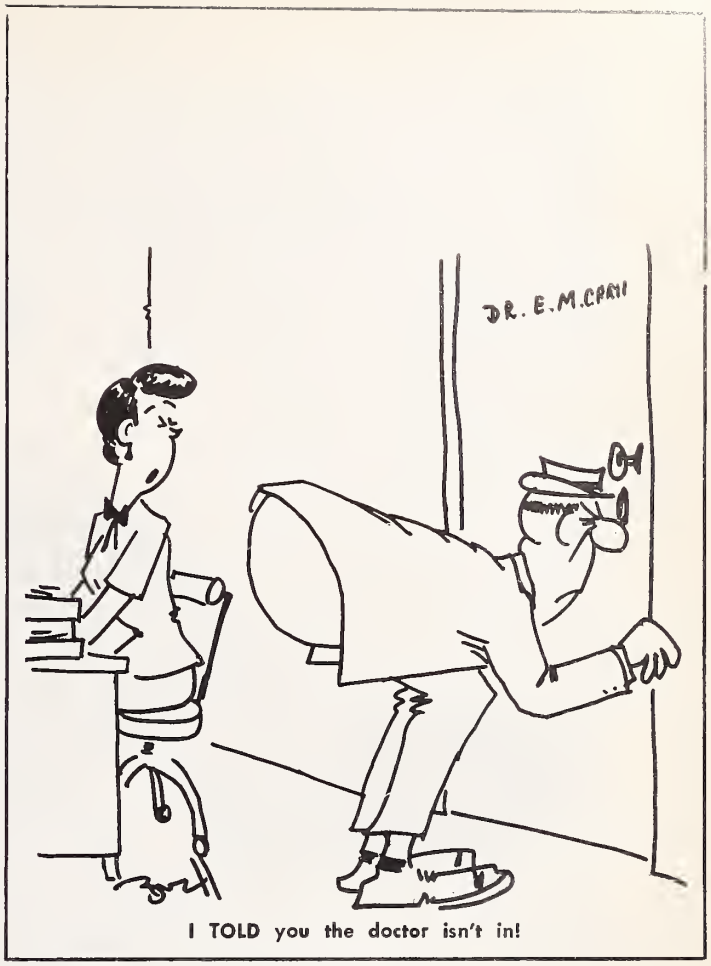
Parke-Davis will market two new consumer items for use as surgical dressings. Readi-Wrap Over-Sponges are 4 x 4 inch gauzes, sealed two in a sterile envelope. Readi-Wrap Composite Padding is a 5 x 9 inch padded dressing sealed in a sterile envelope. Each may be purchased in a box of 10. Each is specially designed for use in convalescent or nursing homes.

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Mead Johnson has two new products to increase the usefulness of the Fer-In-Sol line. In addition to Fer-In-Sol iron drops, Fer-In-Sol iron capsules and Fer-In-Sol iron syrup will be available. The syrup form is useful in pediatric practice but will also be useful for adults who have difficulty in swallowing capsules and tablets.

* * *

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION
Supervised by THE COUNCIL
Volume 62 — July 1969 — Number 7

Phenothiazines, and particulary promazine, are apt to induce withdrawal seizures in patients who are deprived of chronic doses of sedatives.

Sedative Withdrawal Seizures

WESLEY A. KISSEL, M.D.
Indianapolis

WHEN we see a patient who is drugged with a sedative, we often hospitalize him, taking him away from his balm, and sometimes give him a phenothiazine for his "agitation." In such a case we are setting the stage for a withdrawal seizure.

A typical patient of this type is the one with "D.T.'s", impending delirium tremens, a person who has been taking high doses of alcohol over some period of time and then stops. When we see him, he is suffering from the physical, psychomotor and mental symptoms of withdrawal from alcohol. He may appear agitated, and he may have hyperactive muscle stretch reflexes. He probably has no "epilepsy" or convulsive disorder. He has probably never had a seizure before and may never have one again—but he is still ripe for one now.

Withdrawal seizures have been known for a number of years and were studied extensively with the early EEG studies of delirium and clinical electroencephalography. Brownstein and Pacella,[2] Kalinowsky,[5] and Schuster[8] have reported on the convulsions occurring in withdrawal from barbiturates.

Today we see many patients with acute or chronic sedative intoxication. Besides alcohol and barbiturates, patients are using chloral hydrate, paraldehyde and other sedatives in excessive quantities over long periods of time. These patients present a particular hazard. In admitting them to the hospital for other reasons, the physician may unwittingly withdraw them from their sedative.

An accurate and immediate history of sedative intake is vital. When the patient is vague or evasive in discussing his sedative intake, the physician should press for the truth and point out the importance to the patient's safety of an accurate history. Often such a patient presents a new "revelation" in regard to his habit—he now realizes he has been "bad" and wants to quit his alcohol or his barbiturate, now—forever. The physician who concurs wholeheartedly in his treatment may be allowing a withdrawal seizure to occur.

Patients who are presented to the physician with acute sedative intoxication are less likely to have withdrawal seizures and probably are too intoxicated to need any more, or to be able to tolerate any more, sedative. In these cases the chronic artificial inhibition of electrical discharge has not had time to develop.

Epileptiform Activity

It would appear that barbiturates have a dual action. They tend to provoke epileptiform activity by inhibiting the reticular activating system, which then has less desynchronizing effect on the brain waves. Hypersynchrony is allowed to develop and epileptiform activity is enhanced. But the barbiturates also act on the cortex—there high voltage cortical electrical activity is suppressed and seizure discharges are inhibited. The afferent sensory influx to the brain from all sources maintains a pattern of arousal in cortical electrical activity by virtue of its effects on the reticular system, which is stimulated to exert its desynchronizing influence on that activity. So long as this state of desynchroniza-

tion is maintained, epileptiform potentials, by their nature hypersynchronous, are suppressed.[9]

Phenothiazines have a similar effect on the reticular activating system in causing hypersynchrony and enhancing epileptiform activity—but the phenothiazines do not appreciably inhibit the cerebral cortex. McLean and his associates found typical grand mal seizures occurring spontaneously in non-epileptic patients on promazine therapy.[7] They concluded "although promazine would appear to be one of the most frequent offenders [of phenothiazine derivatives producing grand mal seizures], it was not found to produce seizure discharges or other changes in the EEG in the intervals between seizures in this study." In comparing the therapeutic benefits and severity of side effects of various psychotropic drugs, Cattell[3] noted that promazine has a "higher incidence of seizures." These spontaneous seizures do occur, usually, with the higher doses of promazine. Kurtzke found 11 grand mal seizures occurring in six of 21 chronic psychotic patients treated with promazine at 900 mg. or more per day.[6]

Usually lower dosage levels are used in the treatment of alcohol withdrawal, but in the withdrawal state seizures are more likely to occur. Hart compared promazine and paraldehyde in 175 cases of alcohol withdrawal.[4] Grand mal seizures occurred in five of 57 patients treated with promazine alone, in two of 56 with paraldehyde alone, and in five of 62 treated with a combination of promazine and paraldehyde. Seizures occurred in 3.5% of patients with paraldehyde alone and in 8.4% of patients on promazine, with or without paraldehyde. The nurses liked the calming effect of promazine on the patients' agitation and complained about those on paraldehyde asking for more. Apparently, this treatment program was not geared to prevent withdrawal seizures and the patients probably needed more sedative to prevent seizures. Hart did find that hypotension from promazine was a very common problem.[4]

In their comparison of promazine and paraldehyde in the treatment of the alcohol withdrawal syndrome. Thomas and Freedman concluded that promazine is a dangerous drug when given to severely ill delirium tremens patients.[10] Of 106 patients, 51 were treated with promazine and 55 with paraldehyde. On admission 39 were classified as severely ill with D.T.'s. Of 22 treated with paraldehyde the patients were free of symptoms after four days except for one death, a mortality of 4.5%. Of 17 treated with promazine, several had a longer and more stormy course, including hypotension, and six died, a mortality of 35%.

The definite conclusion is that patients withdrawn from heavy sedative intake are likely to have withdrawal seizures—and such patients given phenothiazines, especially promazine, are more likely to have grand mal seizures.

Progressive Symptoms

The "agitation" these patients manifest is somewhat peculiar to the sedative withdrawal state. From Arnold, the progressive signs are: weakness, restlessness, tremulousness, insomnia, blepharospasm (rapid fluttering, involuntary clonus of the eyelids increasing as the glabella—above and between the eyes—is tapped rapidly by the finger), postural hypotension, anxiety, fever, convulsions, psychotic behavior (with visual hallucinosis, confusion, paranoid ideation, formication and delirium) and status epilepticus.[1] Arnold has found that in barbiturate-sedative habits, equivalent to 400 mg. or more of pentobarbital per day, abrupt withdrawal will cause a significant abstinence syndrome. In habits equal to 500 mg. per day, 10% will have seizures and psychotic symptoms, whereas in habits greater than 900 mg. per day, about 80% will have seizures and the majority will have psychotic symptoms.

Such a patient needs a certain amount of sedative to maintain a normative state of neither intoxication nor withdrawal. The advocated treatment program is to use one agent, elixir of pentobarbital, for all sedative withdrawal states. The patient can be given a test dose of 200 mg. of pentobarbital (possibly 100 mg. for elderly or debilitated patients). A patient tolerant to 900 mg. or more of pentobarbital would show no intoxication one hour after a 200 mg. test dose given in a normative state. A tolerance to 700-800 mg. would show only nystagmus; a tolerance of 500-600 mg. would show nystagmus, mild ataxia, and perhaps some dysarthria. Below this level, coarser nystagmus, Romberg sign, pseudotosis, gross ataxia, somnolence and nystagmus on forward gaze would progressively appear. A patient with no tolerance would go sound asleep but be responsive.[1]

The patient is given his tolerance dosage, thus found, in divided doses. Then he is withdrawn at a rate of 50-100 mg. per day, the 6:00 a.m. dose being the next to last to go and the bedtime dose the last.

When the sedative tolerance is found and then the dose is gradually reduced with careful periodic examinations for signs of intoxication or withdrawal, seizures can be prevented. Great caution should be employed in giving these patients phenothiazines, especially promazine.

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A case of Goodpasture's syndrome (glomerulonephritis with pulmonary hemorrhage) occurring in a 74-year-old male is reported. It is the first case reported in an elderly male, and the second reported in the elderly age group.

Goodpasture's Syndrome in the Elderly

(Report of a Case)

*ALDEN T. SCHMIDT, M.D.**
*ELLA STERNBERG, M.D.***
South Bend

SINCE its original description by Goodpasture[1] in 1919, the syndrome of glomerulonephritis with pulmonary hemorrhage is being recognized with increasing frequency. In 1964 the number of cases in the world literature stood at 52 (Benoit)[2]; by 1966 the figure was 105 as reviewed by Davidson[3] and Munro's[4] review brings the total to 143. The presenting features, clinical course and pathological findings of the syndrome are well described,[5-11] with a recent review by Davidson.[3]

The present case of Goodpasture's syndrome is being reported because of the rarity of occurrence in the elderly age group. One of the most constant features of the syndrome, heretofore, has been an incidence limited essentially to the second and third decades of life. Davidson recently altered this hallmark with a report of the disease in a 78-year-old woman.[3]

Case Report

A 74-year-old retired fruit salesman was admitted to the hospital on September 1, 1967, with a three day history of hemoptysis, dyspnea on exertion, orthopnea and paroxysmal nocturnal dyspnea.

He had had a myocardial infarction in 1955. He remained well until September of 1966 at which time he was hospitalized at another hospital for a syndrome resembling pneumonitis (September 2 to October 5, 1966). His blood pressure at that time was 130/60 mm. Hg., pulse rate 80 beats per minute and temperature 101° F. The only pertinent laboratory findings then were a mildly abnormal oral glucose tolerance test and anemia with a hemoglobin of 11.3 Gm. %, serum iron 33 mcg. %, and serum iron binding capacity 258 mcg %. His recovery at that time was slow with failure of bilateral basilar lung infiltrates to clear on an aggressive pulmonary regimen (Figure 1). Bronchoscopy and repeated sputum analyses were non-diagnostic. The patient gradually improved and was discharged, having refused a lung biopsy.

The patient was hospitalized two months later (December 7 to December 15, 1966) with fever and cough. A pneumococcal pneumonia quickly responded to appropriate medical therapy. During his hospitalization he had one episode of hemoptysis. For the first time he was noted to have a small amount of albumin and an occasional red blood cell in his urine. His blood pressure was 124/70 mm Hg., pulse rate 74 beats per minute and temperature 102°F. His chest roentgenogram (Figure 2) continued to show unresolving diffuse bilateral basilar infiltrates, although the patient was clinically asymptomatic. His hemoglobin had remained 11.4 Gm. %, despite supplemental oral iron. The blood urea nitrogen level was 20 mg. %.

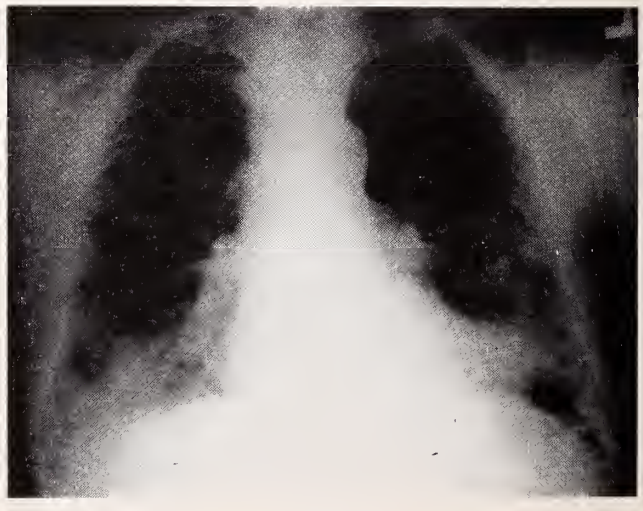


FIGURE 1
POSTEROANTERIOR chest roentgenogram taken September 9, 1966, showing diffuse, parenchymal infiltrates involving the lower portion of both lung fields.

* Formerly from Memorial Hospital, South Bend. Dr. Schmidt is currently stationed at Hanahan, S.C., in the Armed Forces.

** South Bend Medical Foundation, Pathology Laboratory, South Bend.

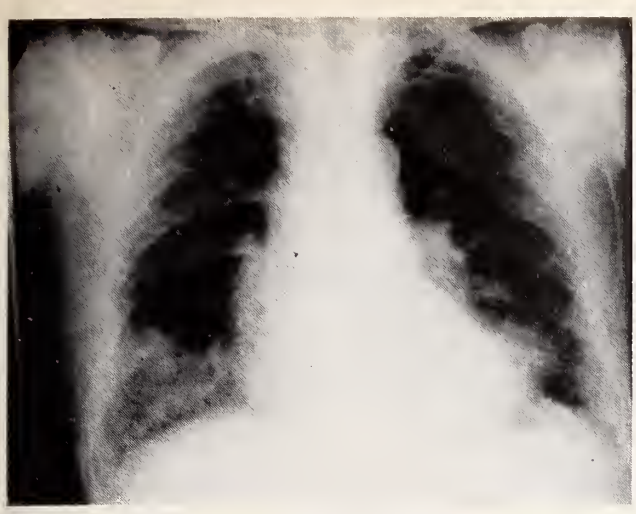


FIGURE 2
POSTEROANTERIOR chest roentgenogram taken December 7, 1966, showing little change from the findings three months earlier.

At the time of his final hospitalization (September 1. 1967) the patient was afebrile, dyspneic and acutely ill. His blood pressure was 192/90 mm Hg., pulse rate 90 beats per minute. During the examination he experienced three episodes of hemoptysis totaling 175 cc. Physical examination demonstrated decreased lung expansion with basilar dullness to percussion and bilateral basilar moist rales with scattered rhonchi. A chest roentgenogram showed diffuse bilateral basilar infiltrative changes (Figure 3).

His clinical course was one of rapid deterioration unresponsive to intensive supportive therapy. He expired 42 hours after admission from massive pulmonary hemorrhage, before more sophisticated investigation could be undertaken.

Laboratory studies during his final hospitalization were as follows: hemoglobin, 7.0 Gm. %, hematocrit 22 vol.%, red blood count, 2,800,000 red blood cells/ cu. mm., mean corpuscular volume 79, mean corpuscular hemoglobin concentration 32. His leukocyte count was 13,800 cells/ cu. mm. with 68% neutrophils, 28% lymphocytes, 2% eosinophils, and 2% monocytes. Urinalysis showed a trace of albumin, 1-3 leukocytes per high power field, innumerable red blood cells per high power field. Serum sodium, serum chloride, serum potassium, cholesterol, bilirubin, total protein, alkaline phosphatase and serum glutamic oxaloacetic transaminase were all normal. Serum calcium was 8 mg.% (normal 9-11.5 mg.%), inorganic phosphorus 5 mg.% (normal 3-4.5 mg.%), serum albumin 2.4 Gm.% (normal 3.5-5.0 Gm.%), uric acid 7.7 mg.% (normal 2.5-7.5 mg.%), blood urea nitrogen 75 mg.% (normal 10-20 mg.%), blood glucose 135 mg.% (normal 80-110 mg.%), lactic dehydrogenase 190 W. U. (normal 30-120 W. U.). Sputum analysis was negative for acid fast bacilli, a normal flora grew on culture and cytologic examination showed multinucleated histiocytes.

Postmortem examination revealed extremely heavy dark red lungs weighing 1520 grams (right) and 900 grams (left). On cut section, both had a diffusely hemorrhagic appearance grossly. On microscopic examination, the alveoli were distended and filled with large numbers of red blood cells, histiocytes loaded with hemosiderin, and fibrin. Some of the alveolar septa were fibrotic, and alveolar lining cells were prominent. There was no evidence of necrosis or inflammation (Figure 4).

The kidneys were enlarged, weighing 230 and 210 grams. Their cortical surfaces were pale and diffusely stippled with punctate hemorrhages. On cut section the cortices were pale. and the medullae appeared congested. Histologic sections of the kidneys revealed diffuse proliferative glomerulonephritis with fairly frequent epithelial crescents. Many of the glomeruli contained large focal areas of fibrinoid necrosis. Only a few glomeruli were completely hyalinized. In the renal cortices there was an interstitial infiltrate of lymphocytes and mature plasma cells. Many of the renal tubules were filled with red blood cells and protein-rich fluid (Figure 5).

The pathologic findings in the lung and kidneys were those described in Goodpasture's syndrome.

Discussion

With the notable exception of the patient's age, the case reported represents the typical picture of Goodpasture's syndrome. The present article is the first report of the disease occurring in an elderly male. There is one case reported by Davidson (1966) of the syndrome in a 78-year-old woman.

The disease has a distinctly male predominance (9:1)[2] and typically begins with hemoptysis, anemia. radiological evidence of pulmonary



FIGURE 3
POSTEROANTERIOR chest roentgenogram taken September 1, 1967, showing unresolved, diffuse, bilateral basilar parenchymal infiltrates having a somewhat conglomerate appearance.

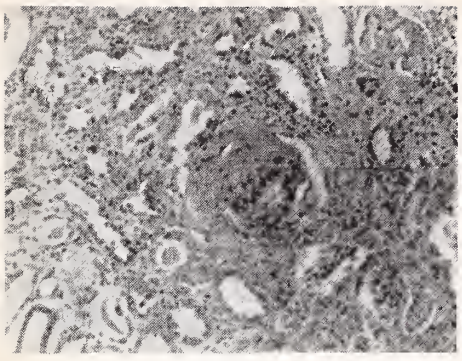


FIGURE 4
MICROSCOPIC section of the lung showing alveoli filled with blood and histiocytes loaded with hemosiderin.

infiltration and often dyspnea in a young male. Hematuria and/or proteinuria occur simultaneously or quickly ensue. In the majority of cases the condition progresses over a variable time period (2-168 weeks)[2] ending in fatal pulmonary hemorrhage or irreversible renal failure.

Several cases of long-term survival[4,12-19] are recorded employing steroids, dialysis and/or renal transplantation. It is admitted by McCall[17] and others that some cases of prolonged survival or apparent "cure" may simply represent a benign or mild form of Goodpasture's syndrome.

The etiology of Goodpasture's syndrome remains obscure. The majority of evidence suggests that an immunological mechanism is operative in the pathogenesis.[2,3,6-8,10,18,20-22]

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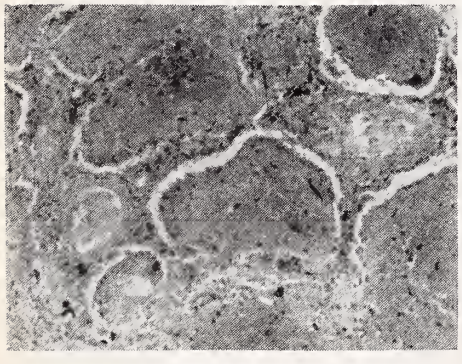


FIGURE 5
MICROSCOPIC section of the kidney showing partial obliteration of Bowman's capsule by crescent formation.

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The Cryoextraction of Cataracts

A Comparative Study With Conventional Instruments

DAVID L. ALVIS, M.D.
GEORGE A. CLARK, M.D.
RICHARD B. RICH, M.D.
Indianapolis

IN planning any intraocular surgical procedure, the surgeon must consider the technic which he can perform with greatest ease, as well as one which will substantially reduce the possibility of complication. Before a surgical technic which satisfies these requirements can gain widespread acceptance, the technic must be superior to those currently in use. From our clinical experience, we believe that the cryosurgical extraction of cataracts is now the procedure of choice in adults, with few exceptions.

The two conventional instruments used most frequently in cataract extraction are the capsule forceps and the erisophake. The former is used to grasp the thin, transparent capsule of the lens. The latter is a suction device which molds itself to the lens by forming a partial vacuum. The primary disadvantage of both instruments is that the lens capsule can rupture during delivery, making complete removal of the lens often impossible. With incomplete removal of the lens, the eye is subject to such complications as secondary cataracts, severe inflammation, infection, a localized autoimmune reaction and lens-induced glaucoma.[1] Cryosurgical technics virtually eliminate lens capsule rupture and thus minimize surgical and post-surgical complications.

Principles Involved

A brief explanation of the mechanical and physical principles involved in cryoextraction will explain why this method is preferred by the authors. If the surface area of the lens capsule in contact with a cryoextractor is the same as that of either conventional instrument, much greater force is required to break a column of ice than the lens capsule.[2] The breaking point of the lens capsule is 7.5 gm., while the breaking point of the ice column at -3°C is 508 gm., a multiplication factor of 65.[3]

Such a physical advantage affords the ophthalmic surgeon a considerable mechanical advantage in manipulating the lens out of the eye. Once the ice ball has formed, the surgeon can direct his entire attention to the lens for removal. With either the capsule forceps or the erisophake, the surgeon must pay attention to the instrument used as well as the counterpressure he is applying to the globe with his other hand. With either conventional instrument applied to the lens, he is constantly concerned about breaking the capsule of the lens or losing his hold on the lens. With the other hand, he must be careful that he is applying pressure in such a manner that vitreous humor does not escape from the eye. The surgeon using a cryosurgical instrument need only worry about his cold instrument touching the cornea, iris or sutures. With adequate preparation these latter situations can be avoided or prevented, without damage to the eye.

This report compares operative and postoperative complications resulting from conventional instruments to those obtained with a cryostylet. In both series, the surgical technics remained unchanged whether done under local or general anesthesia. All cataracts, regardless of etiology or stage of development, are included in this report. Finally, the opinion of the surgeons regarding the ease and safety of cataract extraction is compared in the two series.

Results

Table I lists the total number of cataracts in each series, 361 removed by cryoextraction and 322 removed by conventional instruments. Intracapsular extractions refer to the de-

Number of Cataracts

Cryoextraction	Conventional Instruments
Total 361	322
Intracapsular 351 (97.3%)	309 (95%)
Extracapsular or torn capsule 10 (2.7%)	13 (4.3%)

TABLE 1

livery of the lens with its capsule intact. Extracapsular extraction, or torn capsule, refers to delivery of the lens with its capsule not intact so that further instrumentation of the eye may be necessary to remove all lens remnants as illustrated in Table II. There were fewer broken lens capsules in the cryoextractions than with conventional instruments (Table I).

Operative complications listed in Table II point out the pitfalls in each procedure. Vitreous loss, capsule remnants and retained lens remnants were virtually the same in each series. Iris tears and the adhesion of the iceball to iris and cornea are peculiar to cryoextraction. The most important difference in Table II reflects the greater use of additional instruments to remove all of the lens in the conventional instrument series. Further manipulation with instruments sets the stage for more complications, such as infection, prolonged inflammation and vitreous loss.

Operative Complications

Cryoextraction	Conventional Instruments
Vitreous loss	
6 (1.6%)	4 (1.2%)
Capsule remnants	
1	1
Torn iris	
3	0
Persistent lens remnants	
1	1
Iceball to iris	
4	0
Iceball to cornea	
1	0
Additional instruments	
2 (0.5%)	8 (2%)

TABLE II

Discussion

Tables I and II have compared the results of operative and postoperative complications by the cryoextraction technic and by the use of conventional instruments in a total of 683 cataract extractions, regardless of etiology or stage of maturity. These procedures were performed by three trained ophthalmic surgeons using the same technic in all cases. With the cryoextraction technic there was an incidence of 2.7% torn capsules as compared with 4.3% torn capsules with conventional instruments. Therefore, in only 0.5% of the cases with cryoextraction were additional instruments needed to remove lens remnants from the eye as compared to 2% with conventional instruments. Table II, however, shows that the incidence of vitreous loss, lens capsule and lens remnants was the same in both series.

Surgical complications peculiar to the use of a cryogen in the eye did not occur with the use of conventional instruments. As outlined in Table II they were adherence of the iceball to the cornea and iris, as well as a torn iris. After complete recovery from surgery, vision in these patients was not hampered by these complications. There was atrophy of the iris in all patients at the point of contact, but absolutely no corneal scarring in the patient with inadvertent contact because the iceball was quickly broken with a stream of sterile normal saline.

In both series of cases there was no instance of intraocular infection, severe inflammation, secondary cataract, localized autoimmune reaction, or lens-induced glaucoma as the result of surgery. Meticulous attention to preoperative evaluation, surgical technic, toilet of the wound, and daily postoperative examination all played a part in these highly successful surgical results.

On the surface the data presented in this report would appear to offer no particular advantage with cryosurgical technics when compared with the lens capsule forceps and erisophake. However, the authors feel there are several distinct advantages to using a cryostylet in intraocular surgery.

In cryosurgery, counterpressure from the outside with the surgeon's other hand is unnecessary. Thus the constant threat of vitreous loss, lens dislocation, capsule rupture and trauma to the cornea need not worry the surgeon. He can keep his undivided attention on the lens during extraction.

Two clinical situations lend themselves ideally to cryosurgery. The first is a lens which consists mostly of water. Frequently, such a lens is very difficult to remove entirely by conventional methods, without additional instrumentation. Secondly, in cataract extraction in a one-eyed patient, the surgeon needs every mechanical and technical advantage at his disposal to assure surgical success. The mechanical and physical properties of a cryostylet in these cases is obvious.

Although our statistics failed to reveal any significant difference in the two series, the authors all feel there is less worry about an intracapsular extraction with the cryostylet. Lastly, we have been unable to demonstrate any permanently damaging effect on the function of the eye (vision) by the introduction of a cold instrument.

Summary

Comparison of cataracts removed by cryosurgical and conventional technics demonstrated that the advantage of cryosurgery was a smaller incidence of broken lens capsules and the use of fewer additional instruments to remove lens remnants from the eye. Equally as important, the surgeon has the assurance of using an instrument providing technical ease and peace of mind in both routine and complicated cases. As the experience of the authors and others using cryosurgical technics for cataract extraction continues, we predict that more ophthalmic surgeons will find this method to be the procedure of choice.

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The Case of the Rocky Ripples

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

WHEN does the obvious acquire quotation marks? A mere century plus ago, obstetricians washed their hands after—and not before—delivering the mother of its child. I. Semmelweis had the temerity to make vehement public protest against this "obvious" procedure. It was "obvious" that this Hungarian innovator was cracked; he was, indeed, committed to an insane asylum. He was neither the first nor the last of those martyred by the establishment defending the "obvious."

Now Rob Ruiz came into public acclaim and medical scrutiny in a most obvious manner. A second generation immigrant from Puerto Rico, he had come up the hard way. Having lost both his parents before becoming a teener, he found schooling an impossibility. He did menial jobs; he scrounged for a living but retained the ambition to study nights. At the outbreak of the Korean War, he upped his true age so that he could be accepted by the army. He won a handful of medals; fear had no meaning for him; his missions were filled with zeal and valor. Afterwards, the G.I. Bill gave him the longed for opportunity of really going to school. He finished high school and then went on to college. He then joined the New York City fire department; an impressive record was almost automatic. At age 35, he began developing some disquieting medical symptoms suggesting those that had plagued his parents before their premature deaths. Nevertheless, he insisted on carrying his full share of the work load.

Coruscating Cerberus

Early one morning, the squad he commanded was called to aid at a raging tenement fire. It was Ruiz who plunged repeatedly into the smoke streaming corridors; it was Ruiz that helped carry out unconscious children and adults trapped in the blaze. On a final trip into the inferno, he himself collapsed; he was dragged out unconscious: still alive, but barely!

Now: can there be a better subject for newspaper headlines? Of course, carbon monoxide poisoning, by itself, accounts for almost *one-half* of all fatal U.S. poisonings! But it is seldom that CO produces an accident so spectacularly public as was the fantastic heroism of Ruiz's dedicated courage: all the newspapers of the next day gave him headlined kudos.*

In the NYC metropolitan area over the period of a decade some *80,000* cases of CO poisoning *(The Problem of Nervous and Mental Sequelae in CO Poisoning,* F. H. Shillito, Cecil Drinker and T. J. Shaughnessy, *JAMA* 106:669-674, 1936) had a total of only 43 individuals displaying more or less persisting CNS damage. When our friend Ruiz regained a modicum of consciousness, he continued being markedly disoriented.

* CO is a chemical asphyxiant; the cyanides are also members of this class. The cyanides suppress cell respiration by combining with the cytochrome; CO combines with the Hb of the red blood cells thus stopping the transport of O_2 and CO_2 across the pulmonary membranes. CO is able to do this because its affinity for Hb is something like 200 times greater than is that of O_2. The Henderson-Hasselbalch *equations* express the situation rather well. We need not belabor these elementary relationships taught to all medical students. If we recall that the constant, K, represents a *mass* equilibrium, then we can see at once that CO can be blown out of the body almost as rapidly as it entered—provided the victim is *still breathing* when succor arrives. Recovery is usually rapid and uneventful; the main residua are transient neurological phenomena that bear a direct relationship to the percent saturation of CO-Hb (see J. Rothchild, *Am. Practitioner,* March, 1962, p. 215). This is why pure oxygen—hyperbaric, if available—delivered as rapidly as possible is the treatment of choice. It will be interesting to note whether the presently very experimental fluorocarbons will find a place in the Rx of future CO intoxications.

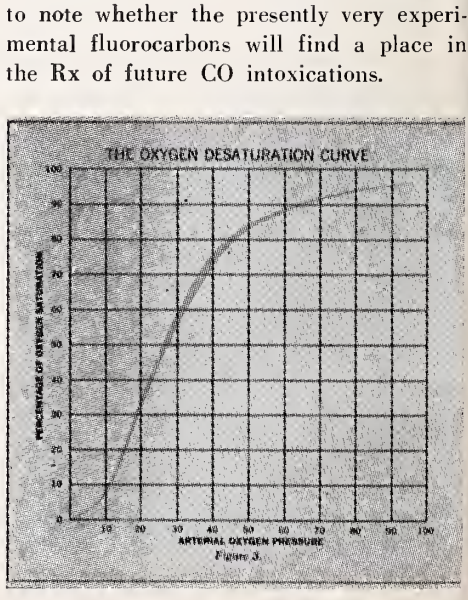


Figure 3.

Also, he developed a *quadriplegia;* especially the upper extremities had marked loss of sensation plus exaggerated abnormal reflexes such as a positive Hoffmann. He was all but dysarthric: a pale shadow of his former, valorous, alert self.

Such a sequela to CO poisoning was a first: RR became a cause celebre, not only journalistically but also medically. A growing procession of 'ologists found their way to his bedside.

Presumably, he had been examined thoroughly at the various V.A. facilities: the internist was surprised to observe angioid streaking in RR's retinae; the ophthalmologist did not have to belabor the obvious. These very characteristic breaks in Bruch's membrane radiate from the optic disc, producing streaks that look—almost—like veins, even if they are actually 5 to 6x wider. The alerted attendings examined the patient's integument with meticulous care. In the folds of the axillae, in the canthi of the eyes, in the skin of the neck and also of the genitalia, they found the burgeoning lesions whose presence they almost had to assume. One of them was snipped off and biopsied.

There was complete confirmation of the diagnosis: the very rare but well-known disease, PXE, pseudoxanthoma elasticum—the Gronblad-Strandberg syndrome. V. McKusick in Harrison gives a most pithy and precise resume.* Anderson's *Color Atlas of Pathology*** has beautiful color plates of same.

Until very recently, PXE had been consigned to the wastebasket of "connective tissue disease, cause and course unknown." In the last decade or so, macromolecular medicine and genetics have found this entity a very rewarding field for study. We now know that, chromosomally, it is a recessive chemical aberration involving not collagen but elastin as the abiotrophic changes develop. Women are twice as susceptible as are men. The biochemists are busy isolating the individual elastin components; much sooner than most of us now realize, the experts will be writing on the blackboard the precise formulae that are at the base of this progeric process. Of course, the exact WHY will still lurk further in the future. Already we know that the elastic fibers in the arterial sheaths become markedly basophilic and develop a fantastic affinity for *calcium.**

Throttled Tutelary

With RR we laid all theorizing aside; we proceeded to perform a few simple procedures. How far had his PXE progressed? Usually, the disease begins to manifest itself before age 20; fatal vascular accidents occur within the next decade or two. Our patient had had routine AP views of the chest: these were unremarkable. A *lateral* view was strikingly unusual and quite revealing (Figure 1). The same could be said of the x-ray of the cranium (Figure 2). In fact, ALL major arteries showed calcifications compatible with the most aggravated stages of extreme, degenerative stages of senility!

These findings gave solid reason for the previously inexplicable, feeble (and almost absent) pulsations in all extremities *and* the carotid arteries. This latter gave cerebral ischemia as the etiology of the mental deterioration. But, then: where did the CO poisoning come in? Surely, Rob Ruiz had all this calcium in him long before his last, selfless, heroic performance! How come? What *was* the physical basis of his elan vital?

The neurosurgeons and the cardiovascular experts attempted angio-



FIGURE 1

cardiography. The thoracic aorta presented them with an impassable barrier! Now, of course they had seen the chest x-rays; they knew that the arch was all but solid gristle and bone—but a complete block? How was that possible? Try as they would, their catheters simply would not slip past the thoracic arch of the aorta and so on to the heart.

Yet—the patient breathed, ate and mentated, after a fashion. What maintained the right arm B.P. at 170/90 and a left arm pressure at 140/110? The heart was somewhat enlarged; the very loud left intercostal space murmur at Erb's point did not seem to have a tangible explanation; how had the previous examiners missed it? The EEG was within normal limits. The EKG was read as only, "ischemic pattern." The usual and unusual blood chemistries were unremarkable. Even the cholesterol was only 290; the calcium was rather low: 8.

RR was transferred to a chronic care facility; the idea was that he would wind up in a VA home if there continued to be lack of improvement. As PXE is notorious for its terminal massive hemorrhages, all the experts ruled out the use of anticoagulants.

* Harrison, *Principles of Internal Medicine*, 5th edition, pp. 1382-83.

** Anderson, *Color Atlas of Pathology*, Vol. 11, p. 371, three cuts.

* A question arises in my mind even if the literature available to me gives no answer. Hans Selye has been able to produce premature aging in his famous calciphylactic experiments. Should someone devise an equivalent to his exuviating rat and thus test the hypothesis experimentally?

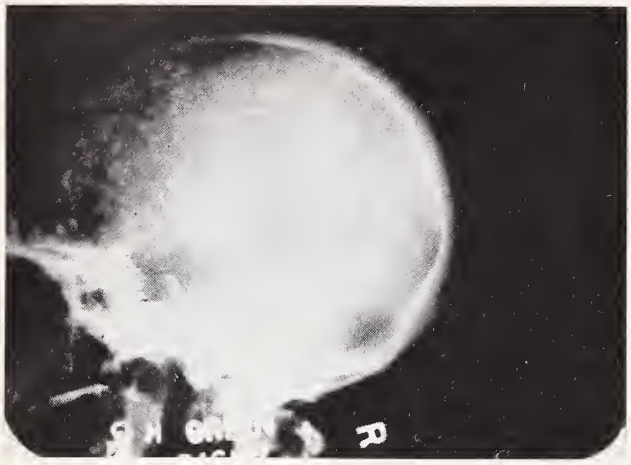


FIGURE 2

The same went for the use of chelating agents.*

The *aortic arch syndrome* is the name given to the group of disorders leading to occlusive changes in the thoracic aorta or its principal branches. Not too long ago, syphilis was a principal culprit producing, for one thing, such complications as aortic aneurysm. Non-specific arteritis (Takayashu syndrome) is quite rare in this country but known to all present day interns. Atherosclerotic, pulseless disease is becoming recognized more and more often in the geriatric patient: it is the frequent forerunner of still later CVA's with all their unlovely complications.

While PXE is an extremely rare phenomenon, with RR, there simply was no question of any other diagnosis. While he had not had—as yet—the lethal hemorrhage, we were resigned to having it materialize eventually. And so: eight months passed. Long since, RR had faded from the headlines. His buddies on the force dropped in for visits. He did get the Carnegie medal. Some of those he had rescued also paid occasional calls, bearing gifts of this and that.

And then: it happened! One quiet morning, the patient sneezed vigorously and started a brisk epistaxis. He became dyspneic, gasping for breath. Before help could reach him, RR had a convulsion; he turned a ghastly purple as all respirations and cardiac activity ceased. All attempts at resuscitation were futile.

The autopsy findings ran into many pages of meticulously documented detail; the pathologists are reporting them elsewhere. For us here, we can quote, "heart . . . normal in shape and consistency . . . the chambers . . . and valves . . . normal; coronary arteries show a slight atherosclerosis. The aorta shows almost *complete* occlusion of the aortic arch by calcium deposits involving especially the first part of the innominate artery."

Unsalubrious Sludge

In sober fact, the apatite deposits made it all but impossible to open the aorta in the usual way. The *rocky ripples* had been sludging the aortic channel until the entire passageway hardly had the diameter of a radial artery!! It was with difficulty that the prosector was able to wash out the final killer thrombus! The illustration (Figure 3) hardly does justice to the actual situation. How on earth had RR been able to retain any mentation? And blood for the kidneys? And all the other body tissues?

RR had had symptoms for almost a year before the heroics at the fire. He had lived for almost another year vegetating after it. How much more calcium had been laid down in this time interval? No one could have more than a very tentative guess. When the attendings looked at the gross material, one of them remarked, "Remember what the explorer said when he saw his first giraffe, 'There ain't no such animal!' "

Well! There it was, not to be explained away. Would anticoagulants have prolonged (maybe) his life? Very possibly! And chelating agents? A most tantalizing thought! I, for one, am being compelled to revise most drastically my thinking re cerebral insufficiency even if already I have advanced some very unorthodox thoughts. (See: "Cerebral Insufficiency," *Geriatrics* 20:213-218, March, 1965.)

Anyhow! RR was signed out by the medical examiner as, "CO poisoning", incidental finding, "PXE"! Obvious? Or:—"Obvious"??? Quien sabe?

The underground informs me that a street will be named after our deceased friend. His shield is displayed conspicuously in the fire department gallery reserved for the commemoration of its heroes. He has been buried with all the pomp and panoply reserved at Arlington National Cemetery for winners of the Congressional

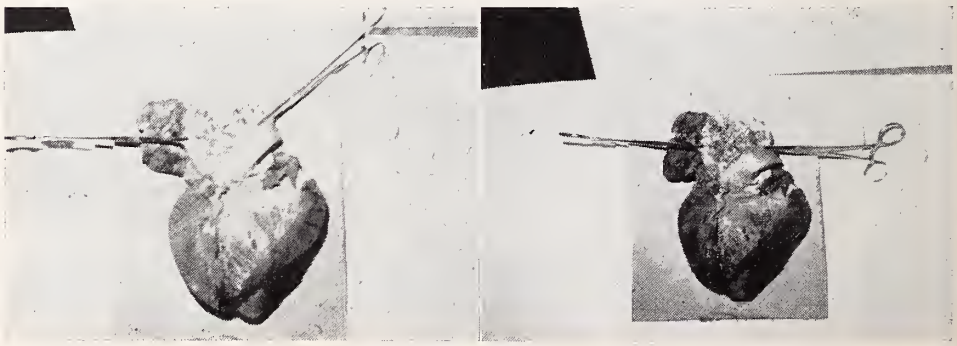


FIGURE 3

* See "The Case of the Arthritic Arpeggio," JISMA 55:1301, 1962.

Medal of Honor and other such truly deserving heroes.

As I did not have the honor of knowing RR in his heyday, I cannot have any truly legitimate speculations anent his motivations. Did he really have an idea that he was genetically doomed to die as his parents had? Is that why he married but refrained from fatherhood? For a Latin, this was being an odd ball, indeed! And—had he been consciously indulging in heroics so as to be able to go out with a bang and not a whimper? Was he courting death all these years?? Again, quien sabe? ◄

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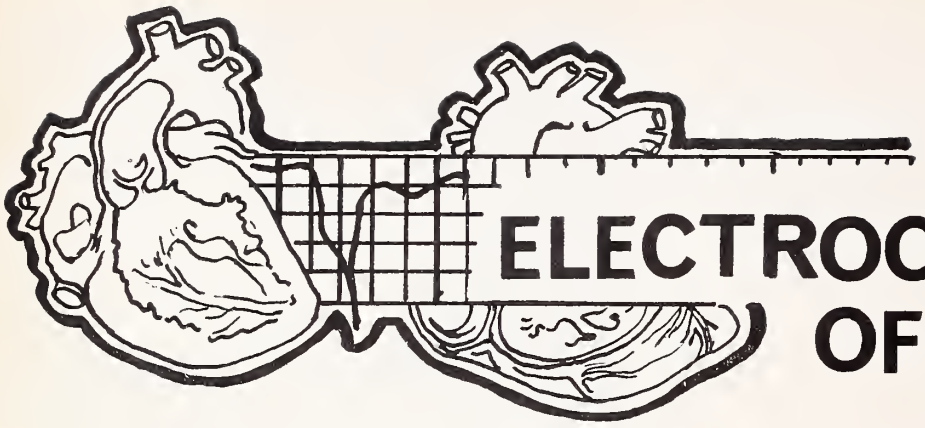
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ELECTROCARDIOGRAM OF THE MONTH

Q Waves In Idiopathic Hypertrophic Subaortic Stenosis

CHARLES FISCH, M.D.
*Indianapolis**

THE electrocardiographic Q wave has over the years been equated with myocardial infarction. Recent evidence indicates that Q waves may be transient, and probably represent reversible "electrical" death rather than true histological myocardial change. In addition, abnormal Q waves have been recorded in patients with emphysema, probably a result of altered electrical field and in patients with various forms of myopathy.

More recently, striking Q waves have been recorded in individuals with idiopathic hypertrophic subaortic stenosis (IHSS). In such instances the deep Q waves are recorded in leads I, AVL, V_5 and most likely represent exaggeration of the septal Q wave.

In the accompanying figure obtained in a 16-year-old girl with IHSS and a gradient of over 100 mg of Hg during isoproterenol infusion, in addition to the abnormal left axis deviation, the precordial leads demonstrated a loss of R wave in leads V_3 with a QS in V_3, V_4, V_5 and a significant Q in V_6. A normal R wave was not registered until the electrode was placed in V_7 position. Such a loss of the precordial R wave is usually strongly suggestive of myocardial infarction.

It is suggested that a final diagnosis of myocardial infarction should be supported not only by the ECG but also by the total clinical picture. ◄

* From the Krannert Institute of Cardiology, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.

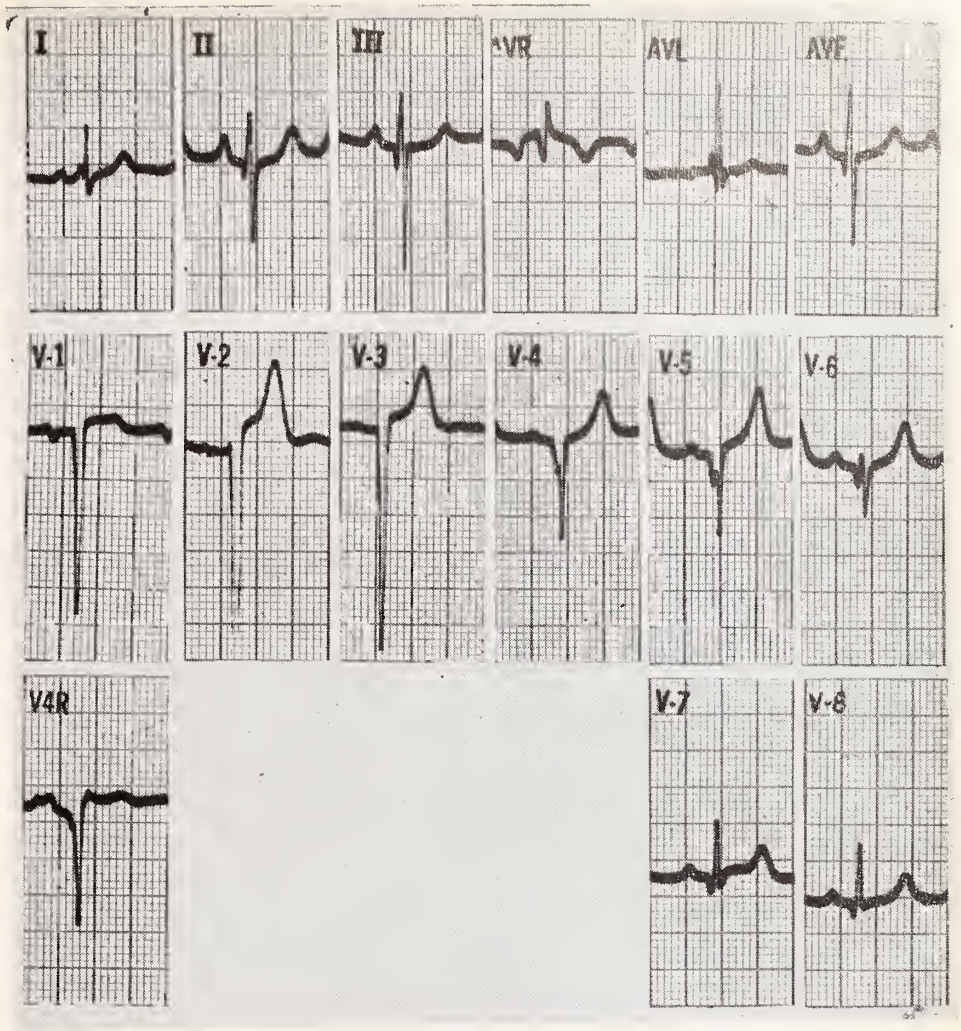


FIGURE 1
ELECTROCARDIOGRAM in IHSS. For details, see text.

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X-RAY CONFERENCE

Traumatic Arteriovenous Fistulae of the Kidney

*ERICH K. LANG, M.D.**
REED A. FONTENOT, M.D.†
BENDEL JOHNSON, M.D.†
RAYMOND W. TURNER, M.D.†
EUGENE ST. MARTIN, M.D.†
Shreveport, La.

THIS 26-year-old colored male was admitted with a penetrating stab wound in his left back.

The vital signs were stable some two and one-half hours after he sustained the injury. "Three glass hematuria" was present. An intravenous pyelogram showed no significant abnormalities: both kidneys showed prompt dye excretion and concentration. A renal arteriogram demonstrated a striking avascularity of the lower pole of the left kidney suggesting interruption of flow to the lower polar artery (Figure I). The pattern was similar to that observed in patients deriving supply to the lower pole of the kidney by a separate vessel. The most striking finding was an almost immediate but faint opacification of the renal vein suggesting the presence of an arteriovenous fistula.

Surgical exploration revealed the stab wound had penetrated the lower pole of the left kidney. Inspection failed to show compromise of the vascular supply and the wound edges were approximated by mattress sutures. The bleeding was easily controlled. Careful and prolonged inspection and observation failed to show any abnormal discoloration of the lower pole of the kidney following this procedure. The wound canal could be followed to the posterior parietal peritoneum and exploration of the abdomen revealed the point of entry of the sharp instrument into a jejunal loop with signs of early peritonitis. A primary surgical closure appeared indicated and was performed.

The immediate postoperative period was uneventful and the patient was discharged on the tenth postoperative day, apparently in good condition. On the 26th postoperative day the patient returned with complaints of massive but painless hematuria. The presence of massive "three glass hematuria" was readily established. Physical examination was unremarkable: in particular, there was no evidence of a bruit over the left kidney.



FIGURE I
AN early arteriographic phase roentgenogram demonstrates simultaneous opacification of renal arteries and vein (arrow). Note the arteriovenous fistulae (arrow).

* Professor and Chairman, Department of Radiology, Louisiana State University School of Medicine in Shreveport, Shreveport, La.

† Department of Urology, Louisiana State University School of Medicine in Shreveport, Shreveport, La.

A repeat arteriogram demonstrated a large arteriovenous shunt in the lower pole of the left kidney with immediate and massive opacification of a huge left renal vein.

The patient was scheduled for a heminephrectomy, however, because of technical difficulties, a nephrectomy had to be carried out. On the ninth postoperative day, the patient was discharged in excellent condition.

Comment

Selective renal arteriography is advocated as a highly accurate diagnostic procedure for the assessment of renal trauma. Frequently the intravenous urogram or a retrograde pyelogram fail to identify the presence of major traumatic changes in the kidney. Even exploration and inspection of the kidney will often fail to ascertain the presence of minor intrarenal abnormalities particularly abnormalities such as arteriovenous fistulae. As in the patient under discussion, the renal arteriogram is superbly suited to identify the presence of such an arteriovenous fistula and, therefore, guide in the selection of the proper surgical procedure. In our experience a heminephrectomy is the procedure of choice after an arteriovenous fistula is demonstrated. Attempts of surgical repair of an arteriovenous fistula within the kidney have so far failed. Our only attempt to occlude the arteriovenous fistula with a gold seed introduced via superselective catheterization of the vessel supplying the AV fistula likewise failed because of embarrassment of the vascular supply to the entire lower pole of the kidney and the necessity to perform a heminephrectomy on the ischemic portion resulting from this procedure.

Arteriography is ideally suited to identify the presence of this not at all uncommon complication of trauma to the kidney and to select the appropriate mode of surgical correction, namely, heminephrectomy. ◄

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A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a post history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplosia, undiagnosed obnormal genital bleeding.

Warnings—Watch for the eorliest monifestations of thrombotic disorders (thrombophlebitis, cerebrovoscular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediotely.

British studies reported in April 1968[1,2] estimote there is o seven- to tenfold increose in mortality ond morbidity due to thromboembolic diseases in women toking orol controceptives. In these controlled retrospective studies, involving 36 reported deoths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluotion indicated thot the differences observed between users ond non-users were highly significont. The conclusions reached in the studies ore summarized in the table below:

Camparison af Mortality and Haspitalizatian Rates Due to Thromboembolic Disease in Users and Nan-Users af Oral Cantraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparoble studies ore yet ovoiloble in the United States. The British data, especiolly os they indicate the magnitude of the increased risk to the individual patient, connot be opplied directly to women in other countries in which the incidences of spontoneously occurring thromboembolic disease may differ.

Discontinue medicotion pending examination if there is sudden portial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdrow medicotion if popilledema or retinal vasculor lesions are found.

Since the sofety of Ovulen in pregnancy hos not been demonstroted, it is recommended that pregnancy be ruled out for ony potient who has missed two consecutive periods before continuing the controceptive regimen. If the potient hos not odhered to the prescribed schedule the possibility of pregnancy should be considered ot the first missed period.

A smoll fraction of the hormone ogents in oral controceptives has been identified in the milk of mothers receiving these drugs. The lang-range effect on the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examinatian should include special reference to the breasts ond pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recammended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence af progestagen-estrogen preporations.

Becouse these ogents may cause some degree of fluid retention, conditians which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require coreful observation.

In breakthrough bleeding, ond oll irregular vaginal bleeding, consider nonfunctianal causes. Adequate diagnostic measures are indicated in undiagnased vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depressian recurs.

Any possible influence af prolanged Ovulen therapy an pituitary, ovarian, adrenal, hepatic or uterine functian awaits further study.

A decrease in glucase tolerance hos occurred in a significant percentage af patients on aral controceptives. The mechanism af this decrease is obscure. Far this reasan, diabetic patients should be abserved corefully while receiving Ovulen.

Because of the effects of estragens on epiphyseal clasure Ovulen should be used judiciously in young potients in whom bone growth is not complete.

The age of the patient constitutes no obsolute limiting factor, olthaugh Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significont ossociation has been shown between use of orol controceptives ond the follawing serious adverse reoctions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such o relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-acular lesians, e.g., retinal thrombosis and optic neuritis.

The following odverse reoctions are known to occur in potients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as obdominal cramps and bloating), breokthrough bleeding, spotting, change in menstrual flow, omenorrhea during ond after treatment, edemo, chloasmo or melosma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion ond cervicol secretions, suppression of loctation when given immediotely post partum, chalestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following odverse reactions have been reported in users of oral contraceptives, on assaciation has been neither confirmed nar refuted: anovulation post treatment, premenstrual-like syndrome, chonges in libido, changes in appetite, cystitis-like syndrame, heodache, nervousness, dizziness, fatigue, backoche, hirsutism, loss of scolp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching. The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increose in prothrombin, Foctors VII, VIII, IX and X; thyroid function: increose in PBI and butanol extractoble protein bound iodine, and decrease in T^3 uptake values; metyropone test; pregnanediol determinotion.



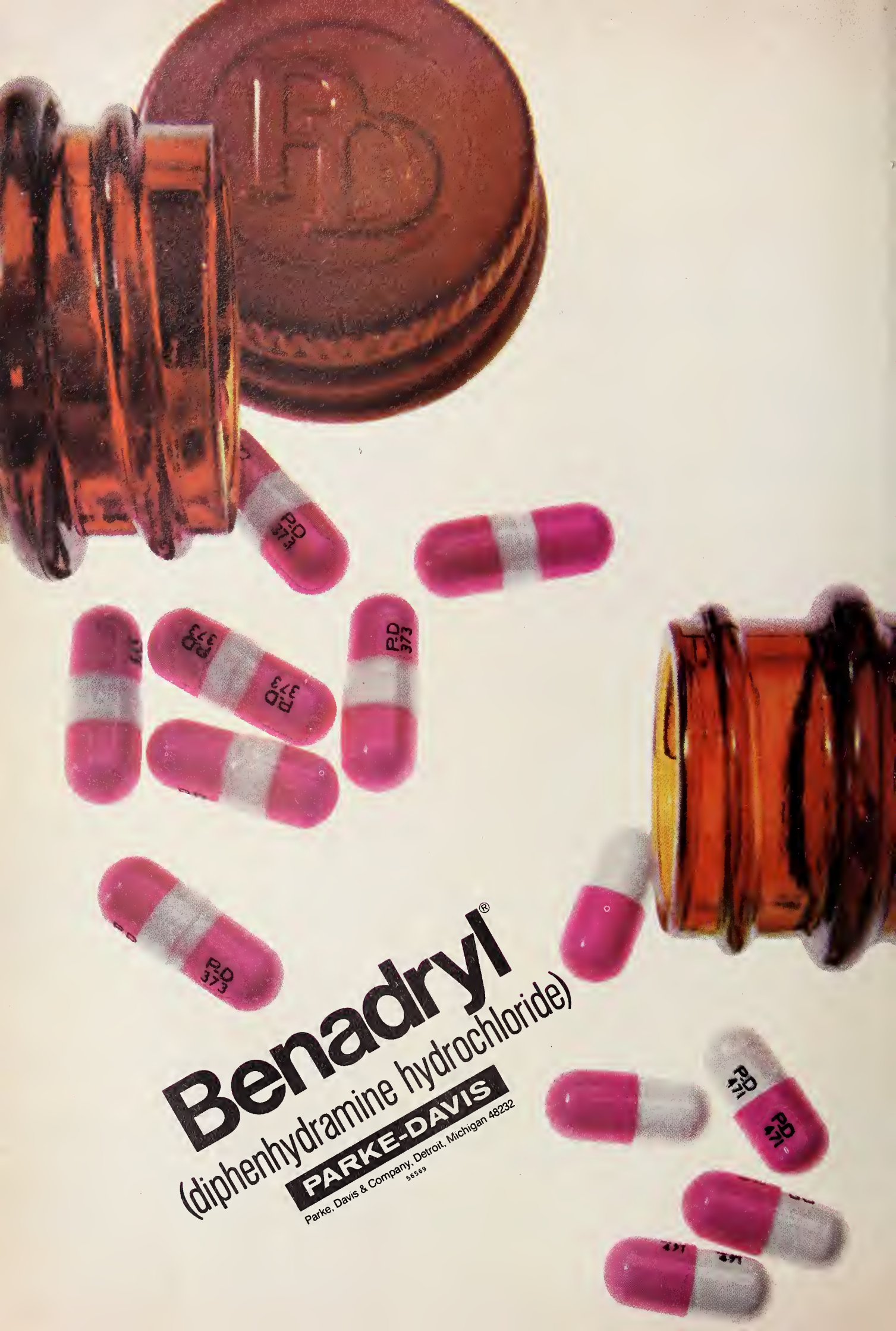
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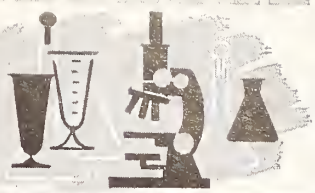
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This series is intended to emphasize the importance of judicious selection and proper interpretation of newer laboratory procedures as applied to differential diagnosis of various diseases. It is edited by Leon L. Blum, M.D., Terre Haute.

Renal Function Tests*

THERE are two general types of renal function tests. One group demonstrates the presence or absence of an active renal lesion while the other group measures the functional capacity of the kidneys. The first group which may give some idea of the intensity of any pathologic process present includes tests for (1) urinary protein, (2) blood pigment, (3) blood cells and (4) casts.

1. *Proteinuria is characteristic* of *all forms of kidney disease* both acute and chronic. This protein is chiefly plasma albumin, which has escaped through damaged glomerular capillaries. It can be idiopathic, as is seen infrequently in adolescents, and can be benign as seen in orthostatic albuminuria.

2. *Hematuria* can occur in all degrees of severity and can originate from anywhere in the genitourinary tract. In acute glomerulonephritis, blood passes through damaged glomerular capillaries, is partly decomposed and red cell casts are formed. Hemoglobinuria is usually due to hemoglobinemia and is not in itself a sign of kidney disease but can cause renal damage by blocking tubules and producing a lower nephron nephrosis.

3. *White cells* in any appreciable number, in properly collected specimens, represent a pathological condition in the genitourinary tract. They are always seen with red cells in Bright's disease. White cell clumps indicate a purulent inflammatory process anywhere in the genitourinary system; however, white blood cell casts are an indication of pyelonephritis.

4. *Epithelial cells* may come from any part of the tract and are hard to identify. Oval fat-containing cells frequently are indicative of tubular lesions.

5. *Casts* are molds of protein material precipitated in renal tubules. An occasional cast is found in normal urine but appreciable numbers indicate glomerular and tubular damage. There are three general kinds, (a) hyaline, which are simple gels of protein, (b) epithelial casts made up of sloughed cells; when these cells are degenerated these casts become granular or waxy and (c) blood cell casts made up of red cells, with or without white cells, are diagnostic of glomerular bleeding. Large numbers of casts indicate an active lesion and are found in all types of renal disease in which proteinuria is present and degeneration of tubular epithelium is taking place.

The second group of tests, by measuring the functional capacity of the kidneys, indicate the degree of damage that is present. The tests, however, give no information as to the presence of either an inflammatory or degenerative process within the kidney. This group includes the (1) dye excretion tests (2) concentration and dilution tests (3) measurement of BUN, creatinine, uric acid and electrolyte constituents and (4) clearance tests.

1. *A dye excretion test* that determines the speed with which injected phenolsulfonphthalein (PSP) is excreted by the kidneys is an old and popular test. PSP is excreted by both glomerular filtration and tubular excretion and the test measures renal blood flow which usually parallels renal deterioration. The dye is best given intravenously and most information is gained from the 15 minute excretion; the normal excretion at this time is 25-50% with an average of 35%. Values may be increased in patients with liver disease and decreased in those taking uricosuric drugs.

2. *Concentration* of urine is dependent upon the quantity of solids excreted and upon the amount of water reabsorbed by the tubules. The measurement of this ability constitutes one of the simplest and best tests of renal function. A specific gravity of 1.018, or higher, in a casual urine specimen usually means the patient has good kidney function. In a concentration test where fluids

* Prepared by the Section on Practice of Pathology in the Private Office, College of American Pathologists.

are restricted (Fishberg, Mosenthal) urine specific gravity should reach 1.020 or higher; values less than 1.018 indicate impairment of renal function and are a sign of tubular inefficiency in relation to the number of glomeruli functioning. Failure to concentrate appears early in kidney damage and may be present before there is nitrogenous retention or before the urea clearance is appreciably reduced. *Dilution* tests are of less value, since inability to dilute occurs much later than inability to concentrate, and the range between normal and abnormal is small.

3. *Serum urea nitrogen and creatinine* values should be determined whenever diminished kidney function is suspected. Urea nitrogen values of 20-25 mg % should be viewed with suspicion and creatinine values over 1.5 mg % definitely indicate impairment of urine formation and excretion. Elevated uric acid values may be found in advanced renal disease.

4. *Renal clearance tests* are the earliest and most sensitive indicators of impaired renal function and offer the best method of determining the degree of damage in acute renal disease. Their effectiveness is due to the fact that they measure both plasma levels and the amounts excreted in a given period of time.

The urea clearance test was the first test devised. Provided that the urine output is over 2 ml. per minute, the average urea clearance is 75 ml. per minute for an individual who has a surface area of 1.73 sq. m. Corrections must be made for smaller or larger persons. An average value of 75 ml. per minute has been established as "maximal urea clearance." When urine output falls below 2 ml. per minute the average urea clearance is 54 ml. per minute, and this is referred to as the "standard urea clearance." The normal range of urea clearance is 70 to 120% of either the standard or maximal clearance. Since blood is never completely cleared of urea and about 40% of that which is filtered by the glomeruli is reabsorbed in the tubules other "Clearance Tests" were devised.

Creatinine is a useful substance for such a test. Since only small amounts of creatinine are reabsorbed by tubular cells, its clearance is not affected by rate of urine flow. Hence, results are expressed only in terms of "maximum clearance rate" and not expressed as percent of normal as is done in the urea clearance test. Normal creatinine clearance ranges from 80 to 120 ml. per minute per 1.73 sq. m. of body surface area.

Serum creatinine concentration does not necessarily reflect the clearance rate since similar creatinine concentrations can be associated with vastly different clearance rates. This emphasizes the value of and the necessity for the clearance test. Creatinine clearance provides more information regarding functional status of the kidney than any other single test.

Inulin clearance is a more specific test since inulin is completely filtered by the glomeruli and not reabsorbed by the tubules. However, the test requires rather intricate chemical procedures, intravenous injections and bladder catheterization and is not generally used. The "maximum" clearance rate is 100 to 150 ml. per minute per 1.73 sq. m. of body area.

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Uniform Anatomical Gift Law

THE bequest of a body or any of its parts, by an individual during lifetime, for use in study or for transplantation purposes after death, has been a matter of considerable social interest during recent years.

Prior to 1968, 44 states had passed laws to govern anatomical gifts. These laws were characterized by a high degree of variation and many were not clearly worded. Not all of them granted immunity from civil liability and only seven granted some protection from criminal prosecution for participants in the gift procedure. None of them gave specific protection for acts authorized by other states.

The above considerations together with the realization that death away from home might jeopardize an anatomical gift because of variations in state laws, has encouraged the promulgation of a Uniform Anatomical Gift Act.

The Act was drafted by the National Conference of Commissioners on Uniform State Laws with suggestions by members of the medical profession and the assistance of the Committee on Medicolegal Problems of the American Medical Association.

Between August, 1968, and April, 1969, 15 state legislatures, including Indiana's, have enacted the uniform legislation into law. The Act is pending in 25 other state legislatures and it is anticipated that many of these states will act favorably during 1969.

The Uniform Act gives full protection from civil liability or criminal prosecution to any person who acts in good faith in accord with the Act or with the anatomical gift laws of another state.

The Act specifies that the fact and time of death shall be determined by a physician, but that this may not be done by any of the physicians who will participate in the removal or transplantation of any part of the dead body.

The Uniform Act also clearly specifies what individuals or what institutions may be the recipients of such gifts. This portion of the Act may be broadened by any one state for special local reasons without impairing the benefits of uniformity.

The Uniform Act carefully protects the rights of those who, for whatever reason, may not wish to make a gift of their bodies or tissues. No gift may be made without consent under the Act. The donor himself has the first right of decision. If he, during his lifetime, authorizes a gift to be made after his death, no survivor has the right to bar his gift. Survivors can make a gift only if they do not have actual notice that the deceased was opposed to making the gift. Thus, the voluntary nature of the gift is assured.

In addition to the need for human bodies for anatomical study, it is estimated that, at the present time, there are at least 10,000 potential candidates for organ transplants per year.

In the words of the AMA committee, "The Uniform Act merits the support of both the medical profession and the legal profession, as well as that of the public."

Guest Editorial

The Ultimate Tranquilizer

MORE than 100 fine pharmaceutical houses make drugs for administration to human beings. A few years ago, only three or four companies were making tranquilizers. These products were quite successful—so other manufacturers tried to share in the tranquilizer market. One of the beauties of our American free enterprise system is that competition spurs each to make something a little better. If the drug has too many side-effects, a competitor strives to develop a drug with fewer, or milder, untoward effects. If too large a dose is required, another competitor aims at a concentrated form of the drug so that

the dose may be reduced. If one tranquilizer sedates too much, another company sets its sights at a nonsedative tranquilizer.

It is a beautiful system, and when it reaches the end of the line it will have produced the ultimate tranquilizer. This will make us feel calm. It will remove fear of failure. It will throw up a selective blanket which will shield us from the winds of ill-fortune. It will bleach out tension in the drive to accomplish. It will lend a rosy tint to the garish yellow of reality, as well as a pink coloration to what otherwise might be the blues. We will never again crusade for the right because to be a crusader you must feel tension. We will accept evil with a shrug, for in a fully tranquilized culture, there is always calm. Everywhere there will be peace, for peace is but the plural of individual tranquility. No one will get worked up over nothing, or over something. We will all realize Sydney Smith's boon: "A man does not choose to be disturbed. He is more thankful to the one who confirms him in his errors and leaves him alone than to the man who instructs him at the expense of his tranquility."

Under the benign bedspread of the ultimate tranquilizer, we will all come to rest. Gone will be the spur to invention, the drive to reform, the divine dissatisfaction that leads to progress. So we will rest, smiling at each other in the beatific calm of the ultimate tranquilizer, until some neighboring tribe, some rude and primitive people, move in on us. They will vanquish us with ease, because no one ever thought of giving the tranquilizer to our enemies as well as to our friends. And when the dust over our civilization stops being radioactive, a 30th century archeologist will find on the tombstone of our culture: "Here lies the tranquil man."— **Henry A. Davidson, M.D., Editor,** *The Journal of the Medical Society of New Jersey* **66:147, April, 1969. Reprinted with permission.**

Editorial Notes . . .

Industries in the United States, such as agriculture and construction, are rated as to size by expenditures and number of employees. Health care has been the fourth "industry" in this classification, but this year it has moved to third. It is exceeded only by the two great industries named above, accounting for about six percent of the gross national product. Its total bill is $51 billion. It may become the largest "industry" by 1975.

The Atomic Energy Commission, two universities, Illinois and Michigan, and the Argonne National Laboratory will conduct a study this summer to determine how rainfall cleans pollutants from the atmosphere. The investigation will take place over the Illinois State Water Survey's rain gauge network, a 1600 square mile grid in central Illinois. Nonradioactive elements will be released from airplanes into the updraft of a storm, after which study of water samples will be made.

Physicians' Drug Manual (*PDM*) **is a monthly cumulative publication designed to furnish physicians with all the information available on drugs.** It is being published under the direction of a panel which includes Dr. James L. Goddard, Dr. Edward R. Annis, and Dr. Chauncey D. Leake. It is being published independently, without government or drug industry financial support. Its price will be $48.50 yearly.

Doctors at the Saucon Valley Country Club of Bethlehem, Pennsylvania, formed a medical committee to improve emergency medical treatment. A sealed medical emergency bag is maintained in a well stocked condition. It may be opened only by a physician. First-aid kits, stretchers, blankets and a resuscitator-aspirator are provided. The committee members conduct a first-aid course each year for all club employees. The program has functioned so well that it has been described in *Pennsylvania Medicine* with recommendations that other clubs do likewise.

Interferon-inducing drugs will inhibit common cold viruses in human cell cultures. One such known as poly I:C (polyriboinosinic polyribocytidylic acid complex) shows a high level of activity. Dr. Maurice R. Hilleman of the Merck Institute for Therapeutic Research has demonstrated that the human cells, in culture, develop resistance to the viruses after administration of the poly I:C. The drug has not been tested as yet in man.



introducing alginates to antacids

for a difference in taste you can feel

Derived from seaweed, and long used to impart velvety consistency to foods, alginates—a Warner-Chilcott contribution to antacid palatability—help 1) erase the chalkiness and grittiness found with some other antacids; 2) dispel unpleasant aftertaste. Like ice cream, Gelusil-M is smooth and creamy, and it has a cool mint flavor. Thus, for your patients Gelusil-M may be better to start on and easier to stay on.

introducing new GELUSIL®-M*

each 5 ml. teaspoonful contains:
500 mg. magnesium trisilicate
250 mg. aluminum hydroxide (Warner-Chilcott)
200 mg. magnesium hydroxide

*U.S. Patent No. 3,326,755

a consistent buffering anticostive† antacid

†Avoids constipation.

See next page for prescribing information

GELUSIL–one name to remember...and a dosage form for every patient



Gelusil®-M Liquid

especially for the constipation-prone patient

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

Supplied: Gelusil-M (spearmint-flavored)—light green bottles of 12 fl. oz.; and a **special hospital pack.** Keep tightly closed—shake vigorously.

Gelusil® Tablets

the universal take-along antacid

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

Regular Gelusil® Liquid

when constipation is not a problem

Pleasant mint flavor...ideal for hospital or home. Available in 12 fl. oz. and 6 fl. oz. bottles and a special hospital pack. An antacid which contains adsorbent and demulcent agents in each 4 ml. teaspoonful: 0.25 Gm. aluminum hydroxide (Warner-Chilcott), 0.5 Gm. magnesium trisilicate (USP).

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Also Available: Gelusil® Flavor-Pack, Gelusil-Lac®.

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The Woman's Auxiliary

REPORTS TO ISMA

There should be full realization of what being a member constitutes. Active medical auxiliary membership can mean that the member is a valuable adjunct to her husband's profession—because she came into this profession when she married him.

One of the most rewarding programs the woman's auxiliary sponsors, and one of which many of you men may be unaware, is the Woman's Auxiliary to the Student American Medical Association, Indiana Chapter. Young women who marry medical students are eligible for membership.



Mrs. Herbert L. Egbert, assisted by Mrs. Stanley M. Chernish, has been the Auxiliary Liaison to the WA-SAMA for a number of years. According to their 1968-69 report, the membership rose to 103 which is an increase of over 50%.

The girls meet for short business meetings followed by programs such as "Self Defense for Women," "Keeping Your Marriage Happy" and "Sex Education for Children."

Along with SAMA (Student American Medical Association) they held the "Holly Berry Ball" in December. In November a number of members tallied votes at the close of election polls for local newspapers. These projects were both profitable and exciting.

Last year WA-SAMA bought medical supplies for the medical clinic which SAMA is operating voluntarily in Indianapolis for needy people. Some of their other projects include voluntary work at Riley Hospital and a donation to the Marion County Welfare Department for special assistance to deserving families.

I gleaned these items from their newspaper—"The Epidemic."

"On Saturday evening, March 16, Dr. and Mrs. Herbert Egbert invited all married freshman medical students and their wives to their home for a buffet dinner."

"We are proud of Mrs. Stanley Chernish, our advisor, who won an award for being an outstanding citizen in the community. We certainly agree with the judges, and we are grateful that she has included us in her activities."

"Our WA-SAMA chapter has donated a new typewriter to the South Side Clinic."

"It was such a delight to meet Mrs. Lewis Morrison, at our April meeting. She will assist Mrs. Egbert and Mrs. Chernish in advising us. We welcome her and hope she enjoys working with us."

"Don't miss the Farewell Dessert honoring Seniors May 15 at Mrs. Egberts!! See you there!!"

"Let's give ourselves a pat on the back. The Indiana University Chapter of WA-SAMA won third place (out of 77 chapters) in the nation for best chapter of the year. This is quite an honor so let's see if we can be first next year!"

Is there any doubt that WA-SAMA members realize what being a member constitutes? We are proud of them and salute our medical auxiliary advisors. These young women will some day be valuable assets to the WA-ISMA.

Sylvia Schneider

What makes a

A man?
Another woman?
Three kids?
No kids at all?
Wrinkles?
You name it.

Is she truly depressed?

Is that why she lets go in your office?

You comfort her.
Talk to her.
And, if she is depressed, consider Pertofrane.
Because
in 3 to 5 days
she can often begin
to cope,
work,
maybe play,
even enjoy.

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In depression...
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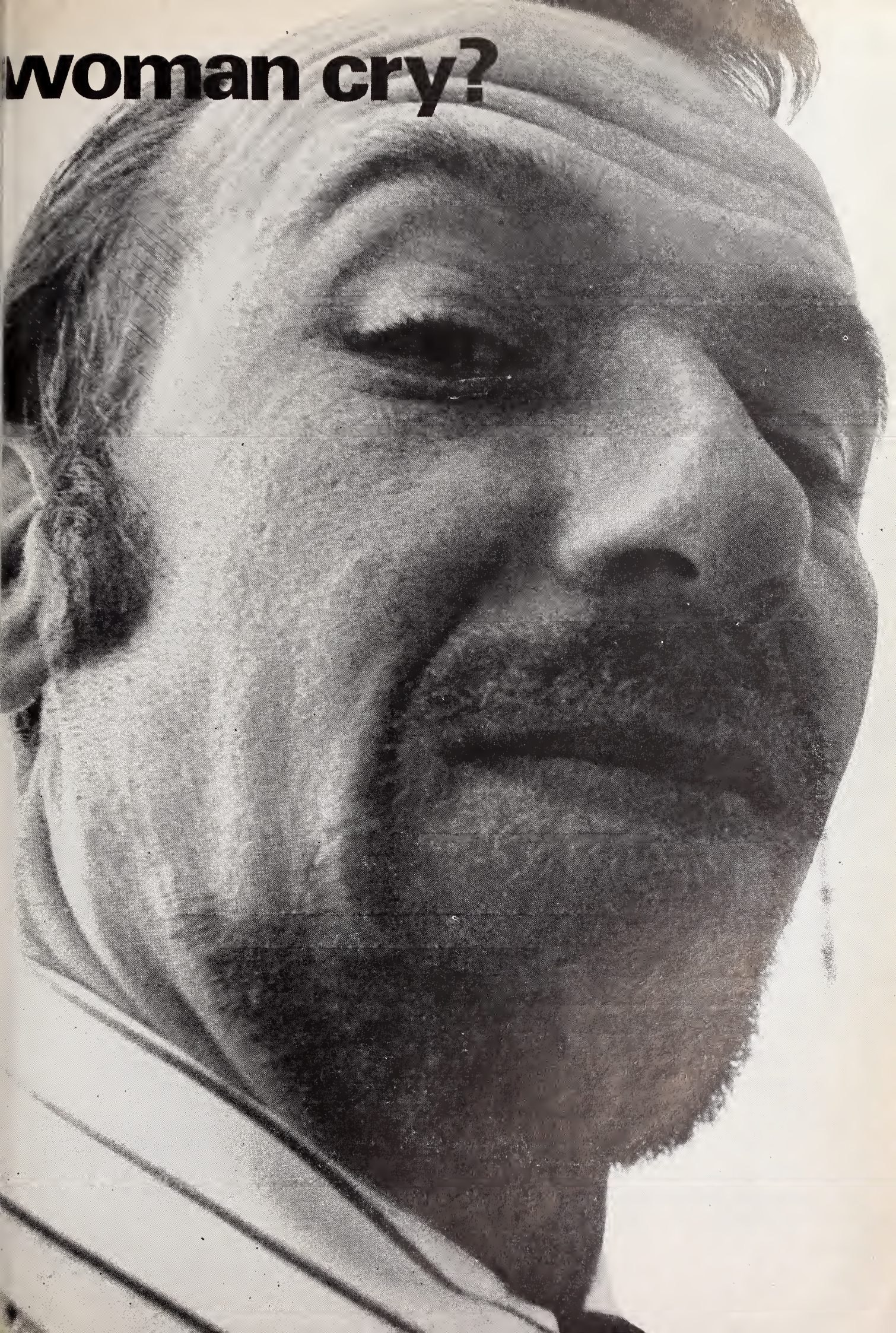
But before you prescribe Pertofrane, please see the full prescribing information and especially note Contraindications, Precautions, Warning, Adverse Reactions and Dosage. A brief summary of that information is included here.

Pertofrane® desipramine hydrochloride

Indications: For relief of depression.
Contraindications: Do not use drugs of the M.A.O.I. class with Pertofrane. Hyperpyretic crises or severe convulsive seizures may occur; potentiation of adverse effects can be serious or even fatal. When substituting this drug in patients receiving an M.A.O.I., allow an interval of at least 7 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.
Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Do not use in patients under 12 years old, and do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk.
Precautions: Careful supervision and protective measures for potentially suicidal patients are necessary. Discontinuation of therapy or adjunctive use of a sedative or tranquilizer may be necessary in the presence of increased anxiety or agitation, hypomania or manic excitement. However, phenothiazines may aggravate the condition. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Carefully observe patients with increased intraocular pressure. Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications. Cardiovascular complications (myocardial infarction and arrhythmias) are potential risks since they have occasionally occurred with imipramine, the parent compound. Desipramine may block the pharmacologic activity of guanethidine and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery in patients on desipramine therapy.
Before prescribing the drug, the physician should be thoroughly familiar with prescribing information, with the literature, with all adverse reactions, with the diagnosis and management of depression, and with the relative merits of all measures for treating the condition.
Adverse Reactions: Dry mouth, constipation, disturbed visual accommodation, anorexia, perspiration, insomnia, drowsiness, dizziness, headache, nausea, epigastric distress, and skin rash (including photosensitization) may appear. Since orthostatic hypotension has occurred, carefully observe patients requiring concomitant vasodilating therapy, particularly during the initial phases. Other adverse reactions include tachycardia, changes in EEG patterns, tremor, falling, mild extrapyramidal activity, neuromuscular incoordination, epileptiform seizures. A confusional state (with such symptoms as hallucinations and disorientation) occurs occasionally and may require reduced dosage or discontinuance of therapy. Rarely, transient eosinophilia, slight elevation in transaminase levels, transient jaundice, or liver damage have occurred. If abnormalities occur in liver function tests, discontinue drug and investigate. Occasional hormonal effects, particularly decreased libido or impotence and instances of gynecomastia, galactorrhea and female breast enlargement have been observed. Urinary frequency or retention may occur. The drug should be discontinued if agranulocytosis, bone marrow depression, jaundice, thrombocytopenia, or purpura occur.
Dosage: 25 to 50 mg. t.i.d. The maximum daily dose is 200 mg. Continue maintenance dosage for at least 2 months after obtaining satisfactory response. Generally, elderly and adolescent patients should be given low doses.
Availability: Pink capsules of 25 mg. in bottles of 100 and 1000. (B) 46-530-E

For complete details, please see the prescribing information.

Geigy Pharmaceuticals
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Ardsley, New York 10502


woman cry?

Art, Hobby Show Planned For ISMA Indianapolis Meeting

Space will be provided at the 1969 annual meeting of the Indiana State Medical Association, Oct. 13-16 at Indianapolis for a Physicians Art and Hobby Show.

Members of ISMA and ladies auxiliary interested in exhibiting pieces and requiring any information regarding this can contact any one of the following:

Dr. & Mrs. C. P. Schneider 2211 W. Franklin St. Evansville	Dr. & Mrs. R. H. Burnikel 2709 Washington Ave. Evansville	Dr. & Mrs. T. E. Caylor 303 S. Main St. Bluffton
Dr. & Mrs. F. H. Coble 51 S. Eighth Street Richmond	Dr. & Mrs. L. G. Montgomery Ball Memorial Hospital Muncie	ISMA Headquarters 3935 N. Meridian Indianapolis
Dr. & Mrs. R. F. Green 614 W. Berry St. Fort Wayne	Dr. & Mrs. T. T. Suzuki Covington	Dr. & Mrs. W. L. Harlan 3700 Bellemeade Evansville

It will be the responsibility of each physician to see that his work gets to the exhibition at the Murat Temple. Final arrangements will be taken care of by Drs. Schneider and Burnikel, co-chairmen.

The ISMA will provide suitable display facilities, but each physician and lady is responsible for transportation costs and any other such expense involved in entering his exhibit.

We solicit your exhibit and that of the ladies auxiliary, to make this the largest and best ever this year.

Application for Space in Art and Hobby Show Exhibit

Mail to:

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville 47712

Name_____

Address_____

City_____

Type and number of pieces to be displayed: Photography_____

Sculpture_____

Crafts_____

Painting_____

Other_____

Estimated amount of space required—lineal or square feet_____

Other information_____



GLEANED FROM THE BRITISH MEDICAL JOURNAL

JACK W. HICKMAN, M.D.
Indianapolis

Post-infarction Anticoagulation Effective in Women

For the past nine years it has often been stated that, although major controlled studies have demonstrated a value to long term anticoagulant therapy for post-myocardial infarction in males, no such benefit was evident for females. Borchgrevink et al.[1] report on a study started in 1960 to test the effectiveness in females. Roughly 80 patients were in both the anticoagulant treated and control groups. All patients were females under the age of 70, who had sustained their first proven myocardial infarction. The treated patients were maintained in the 10%—20% thrombotest levels. The study clearly showed a significant reduction of both mortality and reinfarction in the treated group. No serious bleeding complications occurred in the treated group. This report is the largest one ever published on this subject, and their conclusion that women benefit as much as men from long-term anticoagulant therapy for post-myocardial infarction management should not be dismissed lightly.

Thyroid Carcinoma Rich in Thyrocalcitonin

Now that most people agree that there is such a thing as thyrocalcitonin, investigators are looking for it in association with almost any clinical situation. Tubiana et al.[2] have reported finding greatly increased amounts of this hormone in the tumor tissue, blood and metastatic lymph nodes of seven patients who had medullary carcinoma of the thyroid. This fascinating hormone is thought to have very strong hypocalcemic properties, and to be, therefore, roughly antagonistic to parathormone. Interestingly enough the seven patients reported did not have hypocalcemia, but the authors speculate that other calcium raising mechanisms may have over-compensated to negate the thyrocalcitonin effect in these patients. We can all be certain that similar discoveries of hypersecretion of thyrocalcitonin will be forthcoming in many medical journals in the future.

Pyloroplasty and Vagotomy for Perforated Duodenal Ulcer

Some controversy has continued among surgeons regarding the most desirable surgical procedure for patients with perforated duodenal ulcers. The quickest and safest procedure, and therefore the one favored by most surgeons, is simple closure of the perforation. The great drawback to this procedure of course is that the great majority of patients require further surgery for their ulcer disease at some later time. Partial gastrectomy, which might be curative, is usually rejected because of its greater mortality rate. Machayya has tried a third approach, namely vagotomy and pyloroplasty in 73 cases and reported his results.[3] In his series of patients he found that, if these procedures were carried out within six hours of the time of perforation, his morbidity and mortality figures were quite acceptable and that a hopefully curative procedure had been accomplished. Both morbidity and mortality percentages increased if the surgery was performed after the six hour period. Obviously, a long-term follow-up will be necessary to assess the curative results of the pyloroplasty and vagotomy as far as the peptic ulcer recurrence is concerned, but at least this report should stimulate further interest in this approach.

* * *

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2. Tubiana, M., et al.: Medullary Carcinoma and Thyrocalcitonin, *Brit. Med. J.* 4:87-89, No. 5623.
3. Machayya, M. G.: Emergency Vagotomy and Pyloroplasty for Perforated Duodenal Ulcer: Study of 73 Cases, *Brit. Med. J.* 4:155-156, No. 5624. ◄

It Might Happen Here

A. W. CAVINS, M.D.
Terre Haute

AS the seasons change, the possible threat of snake bite appears on the doctor's calendar. Here in Indiana such a threat is small, statistically, but when encountered "in the flesh" it can be serious indeed. In the April, 1968, number of *The Journal of the Florida Medical Association* was published a symposium on snake bite. This was received here too late to be of much benefit in Indiana in 1968, but the advise therein is still good for 1969.

The opinion of Floridian physicians on treatment of snake bite should be respected, since the average number of snake bite cases per year during 1962-1967 was 178. The symposium includes case reports, experimental studies (including one using venom tagged with radioactive iodine), and a short article on emergency room treatment of venomous snake bite, and it is based on a previous symposium published in the same journal, June 1963, with appropriate updating. The entire presentation is practice oriented and it is interesting to note disagreement on some points among the experts — mostly minor ones.

The emergency room procedure, recommended by Newton C. McCollough, M.D., is quoted as follows:

"Since the publication in 1963 of the emergency room treatment of venomous snake bite as outlined in the *Journal of the Florida Medical Association*, we have, with the aid of the Subcommittee on Venomous Snakebite, come to certain alterations.

"The bite of a venomous snake is accompanied by fang marks, whether it be coral snake, rattlesnake or cottonmouth. If one or more fang marks are present, the patient has been bitten by a venomous snake. Nonpoisonous snakes do not have fangs. Further identification is often produced if the snake has been killed and brought in with the patient. Certainly each hospital facility should attempt to have photographs identifying venomous snakes on the walls of the emergency room. The photographs should be mounted under glass or plastic, otherwise they may be removed by those who do not realize the importance of such a display. If the snake which has bitten the patient has been identified as venomous, either by fang marks or the snake itself, he should be treated as follows.

"Antivenin, should it be deemed necessary, may be introduced via an intravenous catheter or needle with normal saline solution used as a vehicle. If no local or generalized symptoms develop, the continuation of intravenous saline at a slow drip is indicated. If localized swelling and other generalized symptoms such as muscle twitching, shock, vomiting of blood or passing of blood from urine or bowel appear, antivenin should be given intravenously with or without skin testing. Antivenin should be administered until such symptoms disappear or cease to progress, even if the amount of antivenin introduced amounts to 20 units or more.

"If symptoms of anaphylaxis occur, antivenin administration can be stopped with a clamp and proper antidotes of cortisone, adrenalin or whatever is deemed necessary to counteract this reaction to horse serum can be given by the same route. If reaction to the antivenin does occur the patient is better off because this intravenous treatment may be discontinued. Intramuscular injection of antivenin precludes this degree of control. The situation must be considered in the same light as the treatment of diphtheria or gas gangrene. We have been using horse serum for years as a vehicle to give to the patient these snake venom antibodies. Certainly it is only proper that this method should be used because the greater degree of control over any reaction to the horse serum that may occur and the rapid and favorable clinical reaction of the patient to the antivenin. The longer one waits to utilize the intravenous route the more difficult it is to establish. Shock collapses the veins by virtue of hypotension and conduction of antivenin to the vital parts affected is certainly more rapid by the intravenous route.

"There are those who have advocated the intra-arterial use of antivenin, but in the emergency room I believe the procedures mentioned will bring antivenin to the needed areas almost as rapidly and with better control. It is our opinion that this should be, as of this time, the method most desirable. In young children cut-downs may be necessary. If 2 cc. of antivenin intravenously does not produce anaphylaxis, then it will not be produced by 200 cc.

"Local injection of antivenin, intramuscular injection or the use of cold (cryotherapy) is not indicated."

Remarks on coral snake bite are here omitted as irrelevant to Indiana.

The isotope-tagged venom, used in animal studies, yielded most interesting results. Only 22% of it spread from the site of injection in two hours (six animals, at rest without treatment). The spread was much less with use of tourniquet and/or icebag, *but* "upon release of the tourniquet and removal of the ice the tagged venom spread rapidly with detrimental results. If the tourniquet was reapplied and released intermittently, the antigen was actually propelled from the limb, ensued by [sic] generalized venom intoxication, local edema, ecchymosis, cyanosis and paralysis. Prolonged cryotherapy was subject to frostbite which has proven to be a disastrous complication in snake bite patients . . . . Incisions

coupled with bulb suction retrieved an average of 16% of the labeled antigen in the first 10 minutes and 53.6% in 15 minutes . . . . Cruciate incisions produced necrosis in their crossings . . . and a single straight incision through the fang punctures is preferable."

Elliptical excision of the bite is recommended by all. A committee of eight physicians and scientists prepared a condensed tabulation of treatment for venomous snake bite as follows:

"A. First aid

(1) Prevent spread of the venom.

(2) Remove the venom.

B. Definitive treatment

(1) Neutralize the venom and toxins.

(2) Elliptical excision of the bite site.

(3) Support the patient.

(4) Repair."

Cryotherapy should not be used. Physiological rest is beneficial, and exercise (such as running to the doctor, instead of walking) causes rapid spread of venom. As soon as the toxin is neutralized with antivenin, the first aid measures are to be discontinued. Tetanus prophylaxis is mandatory, and it is well to remember that gas gangrene organisms have been isolated from the mouths and venom glands of snakes.

Blood should be drawn early for typing and crossmatching, as hemolysis may occur later. Also recommended is a complete coagulogram, BUN, transaminase, LDH, blood sugar, amylase, Van DenBerg, cephalin flocculation, alkaline phosphatase, total protein and electrophoretic studies. Intravenous infusion should be started early to maintain patency of a vein. The elliptical excision of the bite should be along skin lines.

Polyvalent antivenin is usually given one vial per 500 ml. of saline, or more for severe bite. "Five vials in 500 cc. of 5% glucose and saline have been given. As many as 15 ampules in a single instance over a period of two hours with a total of 20 ampules have been administered to one patient. . . The amount of antivenin administered should be in excess of that needed to precipitate the venom . . ." and this can be estimated only by improvement in the patient as shown by the pulse and blood pressure reaching normal levels and the patient becoming alert and cooperative. It may be doubted that snake bite in Indiana would be this severe, but it is well to be informed in any case. ◄

75 Allendale Pl.
Terre Haute 47802

WANTED: Physicians Locations

GENERAL PRACTICE

Carlos, Antonio A., 7914 Franklin Blvd., Cleveland, Ohio 44102—*General Practice and General Surgery*

Stojanoff, Stefan D., 4435 No. Paulina St., Chicago, Ill. 60640

SPECIALISTS

Bazzan, Michulan, Villa Feliciana Geriatric Hosp., Jackson, La. 70748—*Emergency Room-House Physician*

Habibi, Mohammed, 323 Takht Djamasheed Ave., Teheran, Iran—*Ear, Nose and Throat*

Fink, James M., 18643 Rutherford, Detroit, Mich. 48235—*Internal Medicine*

Klimaitis, Ronald R., 20096 Winthrop, Detroit, Mich. 48235—*Internal Medicine*

Knight, E. Larry, 3010 Wm. Harrison Dr., Biloxi, Miss. 39531—*Internal Medicine*

Konsek, John P., 1369 E. Hyde Park Blvd., Chicago, Ill. 60615—*Internal Medicine*

Versaci, Antonio A., 25 Wildwood Rd., Springfield, Ill. 62704—*Internal Medicine*

Gotay, Jose Belen, P.O. Box 52, Balboa Heights, Canal Zone—*Occupational Medicine and Medical Administration*

Dangle, Harland C., Box 271, Springfield, Ill. 62705—*Pathology*

Chy-Koa, Leticia K., 509 Cambridge, Apt. 15, Clarksville, Ind. 47130—*Pediatrics*

Newman, Roy E., 192 Turner St., Romeo, Mich. 48065—*Radiology*

Ziel, Patricia, Box 576, Whitmore Lake, Mich. 48189—*School Health Service or Outpatient Clinic*

Koa, Elpidio Y., 509 Cambridge, Apt. 15, Clarksville, Ind. 47130—*General Surgery*

Zerbi, Paul G., 145 Lake Dr., Milledgeville, Ga. 31061—*General and Thoracic Surgery*

Vieiralves, Gilson, Box 500, Osawatomie, Kan. 66064—*Urology*

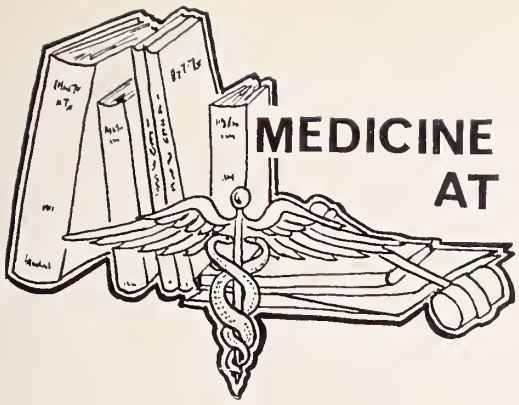
ADDITIONAL LOCATIONS

WASHINGTON—Salem—County seat town—population 5,000. Fully accredited 63-bed county hospital. Fully equipped office and home combination for sale by retiring general practitioner. Contact A. R. Episcopo, M.D., R. R. 3, Salem, Ind. 47167. ◄

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MEDICINE AT LAW

No Liability for Infection After Fracture Reduction—An orthopedist was not liable to a patient for injuries resulting from an infection which developed following the open reduction of a fracture of her right ankle. The evidence established that the orthopedist's treatment of the patient was in accordance with the approved standards of medical care of the community, a Louisiana appellate court ruled.

In the reduction, done on March 3, three incisions were necessary in order to join certain bones by the use of metal screws. Each incision was closed with surgical stitches before the next was opened. All wounds were bandaged and a long-leg cast applied.

When a slight swelling developed in the patient's leg and ankle several days later, the cast was bivalved. A slight fever developed, and the patient complained of a sore throat. The orthopedist diagnosed her condition as acute follicular tonsillitis. Her fever went down after several days of antibiotic therapy.

During the period from March 10 through March 13, the patient's temperature and respiration were normal, her circulation was good, and she was able to use a wheel chair. On March 14, she had a regular diet breakfast and a bath, and she was up in a wheel chair for 30 minutes after breakfast. Then she returned to bed to reduce the swelling of her toes by elevating her foot. At noon, her temperature was 100.2, and at 8:00 p.m., 100.6, but by midnight it was down to 99.6. During this period of elevated temperatures, the patient's pulse did not rise.

At 8:00 a.m. on March 15, her temperature was 99.0 and, after breakfast and visitors, she was up in a wheel chair for 40 minutes. At noon, her temperature was 100.4, her pulse and respiration were up, and her toes were swollen and feverish. The cast was immediately opened. Infection was found. The orthopedist would have operated immediately but the patient had just had lunch and a general anesthetic was to be used. During the operation, which was performed in the early evening, all three incisions were opened. Pus was found and was sent to the laboratory for culture and drug sensitivity tests. Treatment consisting of irrigation with Chloromycetin was started.

The patient was forced to undergo numerous surgical procedures and skin grafts as the result of the infection. She now has a series of scars on her left leg and a "fused" ankle, a result of the infection process in the ankle joint.

The patient contended that the orthopedist was negligent in not having discovered the infection sooner than he did. She offered no expert medical testimony in support of the contention.

All of the expert medical witnesses, including the one who testified for the patient, stated that the decision as to when to open a cast is based on the treating physician's sound medical judgment and is necessarily influenced by many factors. They all said that, since the patient's overall condition was good until March 15, the orthopedist had opened the cast at the earliest point that such a decision appeared to be in order and that he immediately took the proper steps to remedy the condition which he found. They stated that the orthopedist followed approved standards of medical practice throughout his treatment of the patient.

The patient contended that, since she had had her tonsils removed eight years before, the orthopedist was negligent in diagnosing her sore throat as acute follicular tonsillitis and that he should have had a culture made of the bacteria from the area.

The expert witnesses all agreed with the orthopedist's diagnosis. They made it clear that, even after tonsils have been "cleanly" removed, the same area can become infected and swollen and give the appearance to justify this diagnosis. They all also stated that a culture was not indicated.

The patient's failure to present any expert testimony to prove negligence on the orthopedist's part was fatal to her case. She claimed that she was unable to obtain such testimony because of a "conspiracy of silence." There was no evidence of such conspiracy in the record.—*Thibodeaux v. Aetna Casualty and Surety Company*, 216 So.2d 314 (La., Dec. 5, 1968).

Hospital Not Liable for Visitor's Fall—A hospital was not liable to a visitor for injuries sustained when she slipped on an icy patch in the hospital parking lot, an Ohio appellate court ruled. The hospital owed her no duty to remove accumulated snow and ice from the parking lot.

The visitor parked her car in the parking lot when she came to see her husband at noon. It had snowed earlier and parts of the lot had been cleared by piling the snow in banks.

She left the hospital at 9:00 p.m.

While she had been in the hospital some of the snow in the banks had melted and frozen to form an icy patch on the parking lot. She slipped and fell on the patch, suffering injuries.

The visitor contended that the hospital was negligent in failing to exercise the requisite degree of care in providing her with a reasonably safe surface on which to walk.

An occupier has no duty to his business invitee to remove natural accumulations of snow and ice from walks and steps on his premises. Thus, the hospital was not required to do what clearing of the parking lot that it had done.

The visitor contended that, since the hospital had undertaken to clear the parking lot, it was required to do so in a non-negligent manner. She contended that it was negligent in piling up the snow cleared, since it presumably knew that the snow would melt in the daylight and freeze at night.

An occupier of premises has no duty to protect a business invitee from dangers which are known to the invitee or that are so obvious that he may reasonably be expected to discover them and protect himself from them. Whatever presumption of knowledge of thawing and freezing as a natural phenomenon might exist applied equally to the visitor and the hospital.—*Kinkey v. Jewish Hospital Assn. of Cincinnati,* 242 N.E.2d 352 (Ohio, March 11, 1968).

Physician Entitled to Medical Society Membership—A trial court order requiring a county medical society to admit a physician to membership was affirmed by the Arizona Supreme Court. The physician had admittedly not been afforded a due process on his application for membership, the court said. The finding that hospitals in the area made society membership a requirement for the granting of hospital staff privileges was supported by ample evidence.

The court noted that this controversy had originated 12 years ago and had been before it on two previous occasions. Its first decision stated that a medical society's arbitrary denial of membership to a physician was a matter of judicial concern, when hospital staff privileges were dependent upon society membership. It was held that, if the physician could show the existence of a relationship, even though informal, between society membership and hospital staff privileges, he was entitled to a due process hearing on his qualifications for society membership on the same terms as other physicians. The second decision was substantially the same.

As a result of those decisions, which established the law of the case and were binding on the litigants and all courts of the state, the only issues to be resolved were whether the physician was denied a due process hearing by the society and whether there was a relationship between society membership and hospital staff privileges.

The society admitted that it had not afforded the physician a hearing. The evidence clearly established a relationship between society membership and staff privileges. It was immaterial that the evidence did not show that the society had done anything to bring the relationship about. —*Maricopa County Medical Society v. Blende,* 448 P.2d 68 (Ariz., Dec. 11, 1968).

FTC Order on Advertising of Hemorrhoid Remedy—The portion of an order of the Federal Trade Commission prohibiting the manufacturer of a product used in the treatment of hemorrhoids from advertising that the product would relieve pain and itching and reduce swelling associated with hemorrhoids was too broad and was not supported by substantial evidence, a federal appellate court ruled. The court also held that the part of the order which prohibited the manufacturer from disseminating, in connection with the sale of any drug, any advertisement which misrepresented the drug's efficacy was improper. The provision requiring the manufacturer to excise from its advertising a word used to designate an ingredient was upheld. The manufacturer did not contest the provision of the order prohibiting it from advertising that the product would heal or remove hemorrhoids, thus eliminating the need for surgery.

The commission contended that the prohibition of advertising as to relief of pain and itching and reduction of swelling was proper under the technical medical definition of hemorrhoids. Hemorrhoids are technically defined as masses of dilated weak-walled veins located underneath the mucous membrane of the lower protions of the rectum and under the skin of the anal canal and the perianal area.

The court said that, if the advertising were viewed in light of the technical medical definition, all of the advertising would be false, because it was clear from the medical evidence that the product had no significant effect on varicose veins. However, such a limited definition was unreasonable. The only realistic definition of hemorrhoid, as used in the manufacturer's advertisements, was to regard it as including not only the varicose vein but also the tissue contiguous to the vein. This was what the term meant to the average person. This broader definition recognized the symptoms and attendant difficulties associated with hemorrhoids.

In light of the broader definition, the commission's order was too broad in prohibiting the manufacturer from advertising that the product would relieve pain and itching and reduce swelling associated with hemorrhoids. There was no substantial evidence that the product would not do those things.

The provision prohibiting the manufacturer from advertising, in connection with the sale of any drug, any misrepresentation of its efficacy

was also improper. An order of the commission must bear a reasonable relationship to the unlawful practice found. The effect of the provision was to admonish the manufacturer not to violate the law again and it would, in effect, transfer the enforcement of the statute, with regard to the manufacturer, to the federal district courts. That was not within the contemplation of the statute.

The provision of the order requiring the manufacturer to delete from its advertising the word "Bio-Dyne," a name which it gave one of the product's ingredients, was proper. There was substantial evidence showing that the ingredient had no significant value in the treatment of hemorrhoids.—*American Home Products Corporation v. Federal Trade Commission*, 402 F. 2d 232 (C.A. 6, Oct. 18, 1968).

Physician Liable for Failure to Get Informed Consent—A patient whose esophagus was pierced during a diagnostic examination was awarded damages of $20,000 by a Florida trial court jury in her suit against a physician. The jury found that the physician was negligent in not having informed the patient of the possible risks and complications.

The examination was made for the purpose of determinating whether the patient had cancer of the stomach. She did not have cancer. While she was hospitalized for treatment of the injury to her esophagus, she suffered a heart attack with other complications. She was hospitalized for 60 days after the examination.

The physician and his three expert witnesses testified that it was not their custom to tell patients of the possible risks and complications of the procedure.

The patient introduced into evidence a booklet published by the American Medical Association which states that a physician has a duty to obtain his patient's informed consent to a procedure and contains forms which are suggested for use in various situations.—*Willis v. Cook*, Cir. Ct., Dade Co., Docket No. 3770-641 (Fla., Dec.—, 1968).

Treatment Not Intervening Cause of Death—In a prosecution for negligent homicide by operation of an automobile, the jury was properly instructed that it was not to consider whether there was any negligence on the part of the physicians and nurses who treated the victim which could be termed an intervening cause of death, a Michigan appellate court ruled. There was no evidence of any negligence in the medical treatment.

The accused's car collided with a school bus on which the six-year-old victim was a passenger. The bus driver testified that the victim said immediately after the accident that the back of her neck hurt and pointed out a small red mark on her neck.

A registered nurse who checked the children for first aid at the scene of the accident did not remember the victim. Nor did a physician who examined her shortly after the accident specifically remember her.

When the bus driver took the victim home at noon, the driver told her parents about the victim's bruise and the physician's examination. The child was then complaining of a pain in the back of her neck and had a large goose egg on her neck behind her left ear. Late in the afternoon she began to vomit and suffer severe head pain. Her parents took her to the hospital.

At the hospital, x-rays were taken. The neurologist who treated the victim said that, since the x-rays showed no abnormality, he concluded that the victim probably had the flu. However, he kept her in the hospital overnight. When the neurologist came to the hospital the next morning, he was told that the victim had suffered a strange spell a short time before, in which she had stiffened, but that it had lasted only a short time and she had resumed her more or less sleepy attitude. There had been on change in her blood pressure, pulse, temperature or anything else.

While the neurologist was discussing the victim's case at her bedside with five other physicians, she suddenly stiffened out and stopped breathing. Attempts to resuscitate her were unsuccessful. An autopsy disclosed that she had had a large epidural hemorrhage. The hemorrhage was caused by two small fractures at the base of the skull.

There was nothing in the record showing negligence on the part of any physician or nurse who examined or treated the victim. Thus, the trial court properly instructed the jury not to consider the question of whether negligent treatment was an intervening cause of death.—*People of the State of Michigan v. Jones*, 163 N.W. 2d 266 (Mich., Aug. 26, 1968).

Hospital Records Admissible—In a prosecution for assault and battery, a hospital's records as to the victim's injuries and treatment were properly admitted in evidence, even though they were not authenticated by the official custodian of the hospital's records, the Court of Special Appeals of Maryland ruled.

The hospital records were produced by the physician who first treated the victim. The physician was familiar with the hospital routine and knew that it was the hospital's regular course of business to make such records. The records were thus admissible under the Business Records Act.—*Ferrier v. State of Maryland*, 248 A.2d 501 (Md., Dec. 18, 1968).

Accused "Tranquilized" at Time of Plea—Evidence that a prisoner was taking tranquilizers at the time that he entered a plea of guilty to a charge of homicide was not sufficient to establish that the plea was not voluntarily and understandingly made, a New Jersey trial court ruled. The court also said that the evidence failed to establish that the medical treatment given the victim for her wounds was a supervening cause of death.

Continued

The victim was the prisoner's wife. He shot her in the stomach, perforating the small bowel in eight places. Surgery performed in an attempt to save her life was unsuccessful.

The prisoner alleged that at the time of the trial, he was under tranquilizing medication to alleviate shock and depression caused by his wife's death, and that, as a result, he did not have the necessary mental capacity to voluntarily and understandingly enter the guilty plea.

According to Webster's Dictionary, tranquilizers are drugs used to reduce anxiety and tension without reducing mental alertness. The record showed that the prisoner entered the plea after consulting with his counsel, and that it was not accepted until the trial court had made an exhaustive inquiry into his comprehension of the nature and consequence of his plea.

The prisoner also contended that there was new medical evidence as to the cause of the victim's death. A physician testified that he had examined the victim's hospital records and the autopsy report. He stated the opinion that she died from a lack of blood before the surgery and insufficient blood transfusions during her stay in the recovery room. He said she would have lived if more blood had been transfused into her after the surgery.

The physician who treated the victim testified that she died from shock and injury caused by the gunshot wound.

The general rule is that one who has injured another is criminally responsible for the death, even though different or more skillful medical treatment might have saved the victim's life. According to the law, the death was immediately caused by an operation which was made necessary by the injury. However, if gross maltreatment of the wound had been the sole cause of death, this would have constituted a defense for the inflicter of the wound. In this case, the evidence established that the medical treatment received by the victim was in accordance with accepted standards of practice.—*State of New Jersey v. Clark*, 248 A.2d 559 (N.J., Dec. 4, 1968).

Kintner Regulations Again Held Invalid—The income of physicians who were employee-shareholders of an Arizona professional corporation operating a clinic was improperly taxed as income from a partnership, a federal trial court ruled. The Kintner regulations, on which the government's assessment of taxes was based, were held invalid. This is the fifth federal trial court to hold the regulations invalid.

The corporation was duly organized under the Arizona professional corporation law. In its operations, it complied with all of the requirements of that law and with all of the provisions of its constitution and bylaws. It also complied with the requirements imposed by the Internal Revenue Code on corporations organized and operated for profit.

Since the clinic is validly incorporated under Arizona law, it cannot, under the express, unequivocal provisions of the Code, constitute a partnership for tax purposes. Therefore, it must be treated as a corporation for federal income tax purposes. The Kintner regulations, by which the commissioner has attempted to circumvent the express, unequivocal language of the Code, are invalid, the court said.—*Cochran v. U.S.*, F. Supp.—(D.C., Ariz., Feb. 12, 1969).

Damage Award Against Physician Held Excessive—A judgment for a patient in her suit against a physician for alleged negligence in diagnosing her condition and in hospitalizing her for longer than was necessary was improperly set aside by a trial court. There was sufficient evidence to support the finding that the physician was negligent, the Colorado Supreme Court ruled. However, the damage award of $15,000 was excessive. A new trial was ordered on the issue of damages alone.

The physician hospitalized the patient immediately after she consulted him. The evidence showed that this was proper. However, there was evidence that his diagnosis and treatment were not in accord with accepted standards of practice and that as a result he kept her hospitalized for 60 days, which was much longer than was necessary. There was evidence that this prolonged hospitalization caused the patient mental suffering, anguish, and apprehension that she would be a cardiac cripple. The evidence was sufficient to establish that there was negligence on the physician's part which caused the patient injuries and for which the physician was liable.

However, the award of $15,000 to the patient was excessive and was, in all probability, motivated by passion and prejudice. The evidence showed that some part of the 60-day hospitalization was indicated and was of benefit to the patient. There was also evidence that some of the medicines given the patient by the physician to keep her tranquilized and to alleviate an obvious swelling of her legs were indicated by her symptoms and were properly administered. There was also evidence that the patient made a speedy and complete recovery, resuming all normal activities shortly after being released from the hospital.—*Larson v. Lindahl*, 450 P.2d 77 (Colo., Dec. 9, 1968). ◄

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—May, 1969

Disease	May 1969	April 1969	March 1969	May 1968	May 1967
Animal Bites	1431	937	556	1168	955
Chickenpox	637	737	714	482	274
Conjunctivitis	199	128	141	116	81
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	36	81	89	12	21
Gonorrhea	582	541	485	465	371
Impetigo	98	90	93	62	54
Infectious Hepatitis	67	53	35	54	52
Infectious Mononucleosis	118	85	123	221	64
Influenza	1284	6135	8788	444	277
Measles					
Rubeola	133	108	131	143	129
Rubella	602	667	338	203	87
Meningitis, Meningococcal	5	7	7	2	6
Meningitis, Other	2	11	6	6	5
Mumps	485	461	337	701	665
Pertussis (whooping cough)	9	0	3	33	20
Pneumonia	271	241	295	166	143
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	865	1109	1608	629	417
Syphilis					
Primary & Secondary	39	22	30	38	9
All Other Syphilis	118	123	117	124	100
Tinea Capitis	10	18	6	6	2
Tuberculosis (Active)	42	85	91	89	77

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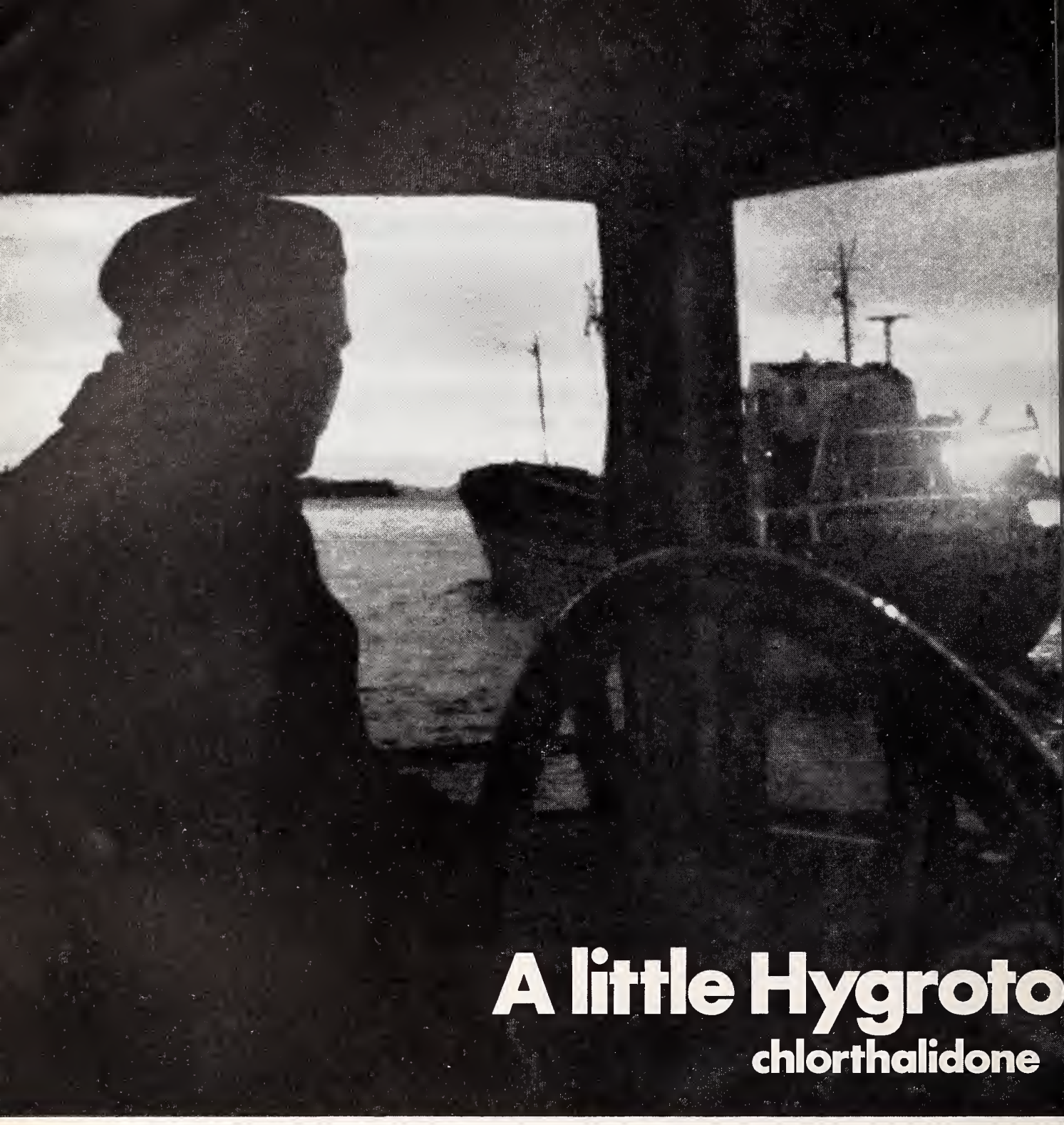
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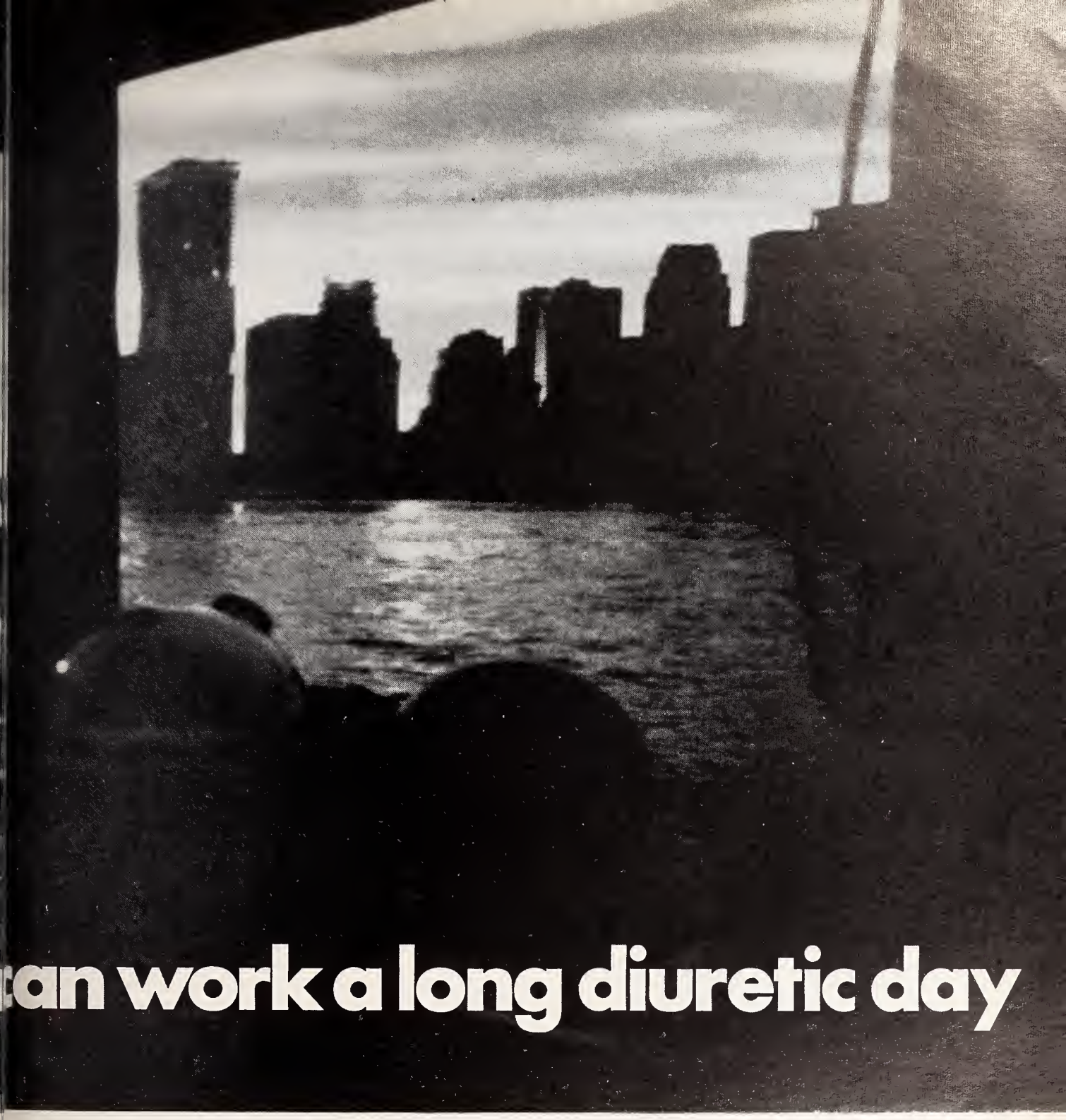
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neck the prescribing information. It's summarized on the next page.

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Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

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ABSTRACTS, BOOK REVIEWS

PHYSIOLOGY OF THE GASTROINTESTINAL TRACT

Texter, E. C.; Chou, C-C; Laureta, H. C., and Vantrappen, G. R., The C. V. Mosby Company, St. Louis, 1968.

In "Physiology of the Gastrointestinal Tract," emphasis is centered on the ways in which certain disease states disturb normal physiologic mechanisms.

The book is divided into chapters discussing physiologic mechanisms, including the splanchnic circulation, motor mechanisms, secretion, and digestion and absorption. Each chapter presents a logical and comprehensive exposition of the topic covered, combining scientific background with a humanistic, clinical approach even though the primary emphasis is on perverted mechanisms rather than clinical states. A remarkably high degree of writing clarity is achieved. One can *read*, rather than be forced to *figure out*, this book.

Clear black and white illustrations are used throughout the text. The bibliography is adequate, as is the index. Authorities in their field, the authors have the happy facility of keeping the reader in mind. This thoroughly scientific, yet interesting, book should be welcomed by physicians dealing with gastrointestinal disorders, be they family physicians or specialists. I recommend it without qualification.

W. D. SNIVELY, JR., M.D.
Evansville

LAW AND CONTEMPORARY PROBLEMS

(Quarterly published by the Duke University School of Law); "Medical Progress and the Law," Durham, North Carolina. Volume 32, No. 4, autumn, 1967, $3.00.

This quarterly discusses legal problems of medicine commonly discussed in various medical periodicals. I feel it is more legal-medical than medical-legal; i.e., more for the lawyer interested in medical problems than for the physician interested in legal problems. It develops these problems more thoroughly than most physicians without uncommon legal interest would care to investigate.

Topics discussed are (1) the role of the law in medical practice, (2) organ transplantation in medical and legal perspectives, (3) human experimentation: ethics in the consent situation, (4) regulation of prescription drug advertising: medical progress and private enterprise, (5) legal aspects of computer use in medicine, (6) the changing structure of medical practice, (7) innovation and experiments in use of health manpower—the effect of licensure laws.

This quarterly shows once again the disparity of legal and medical views. These problems had best be quickly solved by medical ethics—such as they are—rather than waiting the writing of laws. A certain amount of medical ethics can be taught in pre-med and in medical schools. More still can be learned by precept. The basis of medical ethics is *dedication*—developed by habit of service and hard work.

Rate this quarterly for special interest in the topic named above.

ALVIN J. HALEY, M.D.
Fort Wayne

NEPHROLOGY

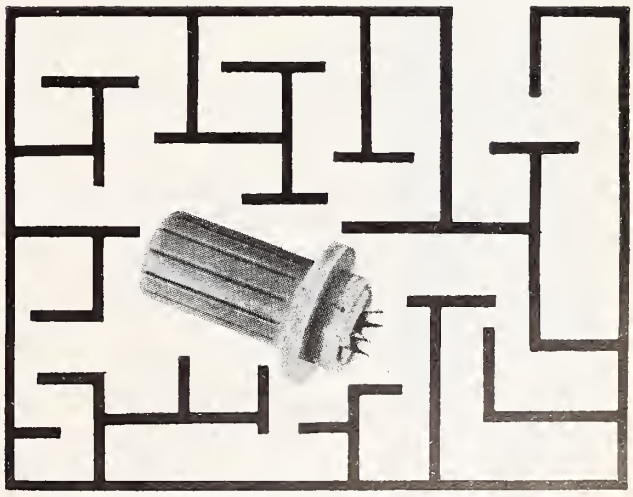
Translated from the French by A. Walsh; Authors: J. Hamburger, G. Richet J. Crosnier, et al., W. B. Saunders Co., Philadelphia, 1968; two volumes—1312 pages and 428 figures, massive bibliography after each chapter; $50.00.

As medicine progresses, more and more subspecialties emerge to encompass their particular field. The present set (to me) marks nephrology as having come of age! As an internist, I have watched carefully the many advances in our understanding of kidney pathology. I have on my book shelves monographs devoted to renal diseases: several inscribed directly to me by the authors.

Yet, it is only in this work that we arrive at an orderly—and exhaustive—presentation of the entire kidney panorama. We start with the anatomy, embryology, physiology, etc., of the organs and then proceed in orderly fashion through all the usual and not so usual pathological conditions that have ever been described. Whole chapters are devoted to such exotics as "Cacchi and Ricci Disease"—have you ever heard of the condition?

The pictures are superb, the bibliographies exhaustive; the comments authoritative and enlightening. The printing and binding are excellent; I saw nary a typographical error. All-in-

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all, a landmark work well worth its $50.00 price. All libraries in hospitals and medical schools should have it. Most internists might want it gracing their personal shelves.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

Abstracts From Various Literature, Prepared by AMA

LIMITATIONS OF BLOOD REPLACEMENT WITH ELECTROLYTE SOLUTIONS

B. F. Rush, Jr., et al. (University of Kentucky Medical Center, Lexington)

Arch. Surg. 98:49-52, (Jan.), 1969.

A randomized, prospective, controlled study of 100 patients losing more than 400 cc of blood at operation is presented. Blood loss was replaced with blood in 52 and Hartmann's solution in 48. The amount of Hartmann's solution given was controlled by repeated hematocrit determinations and blood was given when hematocrit fell to 28 or below. Only seven of the 48 saline-treated patients required blood, although the average blood loss in 20 patients losing more than 1,000 cc was 1,880 cc. No pulmonary edema or increase in morbidity or mortality was seen in the saline group. Use of the hematocrit seems to be a safe and convenient method for monitoring replacement of blood loss with noncolloidal solutions.



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CORONARY CARE UNIT: APPRAISAL OF ITS PSYCHOLOGICAL HAZARDS

T. P. Hackett (Massachusetts General Hospital, Boston) N. H. Cassem, and H. A. Wishnie

New Eng. J. Med. 279:1365-1369, (Dec. 19), 1968.

Fifty patients admitted to a coronary care unit with the diagnosis of acute myocardial infarction were carefully interviewed at appropriate intervals from day of admission until discharged. Although 40 patients showed evidence of anxiety and 29 of depression, the incidence of severe psychological reactions was low. Only five patients became delirious, one of them psychotic; three of 11 reported fear in response to witnessing cardiac arrest. Six survivors of cardiac arrest suffered no major emotional impairments. Monitoring equipment, disliked by six patients, was reassuring to 26; 14 patients liked watching the oscilloscopic pattern. These and other data suggest that far too little attention has been paid to the potential of such machinery for reassurance. Denial provided the main psychological defense for 46 patients. Patterns and degree of use were specified. The possible significance of denial for early stages of recovery were suggested by the significantly higher immediate mortality among non-deniers. Specific data from coronary care units differ markedly from those of recovery rooms and other intensive care units, indicating the need for caution in any general application of the term "Intensive Care Syndrome."

CHILD-RESISTANT CONTAINERS CAN PREVENT POISONING

R. G. Scherz, G. H. Latham, and C. E. Stracener (Pediatric Service, Madigan General Hospital, Tacoma, Washington)

Pediatrics 43:84-87, (Jan.), 1969.

During the period May 1, 1967, to April 30, 1968, prescription tablet and capsule medications from the pharmacies of Madigan General Hosp. and McChord Air Force Base were dispensed in 270,000 child-resistant containers. Poisonings from all prescription medications decreased from 15.8 to 8.2 poisonings per 10,000 pediatric outpatient visits. The most significant change was a 90% decrease in poisonings due to prescription tablets and capsules dispensed in plastic vials originating from Madigan and McChord Air Force Base pharmacies during the test period. Widespread use of the test container may significantly reduce accidental childhood poisonings.

ADSORPTION OF INSULIN TO INFUSION BOTTLES AND TUBING

S. Weisenfeld et al. (Jewish Hospital, 555 Prospect Pl., Brooklyn, N.Y.)

Diabetes 17:766-771, (Dec.), 1968.

Adsorption of clinically used quantities of insulin to infusion systems was studied. Isotonic saline solutions containing trace quantities of ^{131}I beef insulin, with or without varying amounts of non-radioiodinated (carrier) regular beef insulin, were added to bottles of 500 ml infusion sets. The solutions were then allowed to flow out into collection beakers. Adsorption was assessed by measuring the decrease of radioactivity in the solutions and recovery from the bottles by 30% potassium hydroxide (KOH). The influence of human serum albumin (HSA) on adsorption was evaluated by repeating the experiments after HSA was added to the infusion fluid. Adsorption of ^{131}I insulin to the bottles alone averaged 19.5%, 8.1%, 8.5%, and 7.4% when 0, 10, 20, and 40 units, respectively, of carrier insulin were present in the contents. HSA reduced the adsorption to 0.8%, 0.6%, and 1.8% with 10, 20

nd 40 units present, respectively. Adsorption to both bottles and ubing was 37.7%, 30.8%, 21.9%, and 18.7% with 0, 10, 20, nd 40 units presents, respectively, and HSA reduced this to 4.4%. .4%, and 6.6% with 10, 20, and 40 units, respectively.

ERCUTANEOUS TRANSHEPATIC CHOLANGIOGRAPHY IN THE DIAGNOSIS OF OBSTRUCTIVE JAUNDICE

K. Junghanns et al. (Chirurgische Universitatsklinik, Heidelberg, West Germany)
Deutsch Med. Wschr. 94:24-27, (Jan. 3), 1969.

One hundred and forty-three percutaneous transhepatic cholangiographies were performed in 140 patients aged between hree weeks and 83 years. In 97 (76%) percutaneous puncture vas successful: in 95 the diagnosis was confirmed by operation, iver biopsy, or necropsy. Percutaneous transhepatic cholangiography provides quick diagnosis in jaundiced patients, giving lso an exact indication for operative intervention.

MECHANISMS OF DEATH IN SHALLOW-WATER SCUBA DIVING

E. M. Cooperman, J. Hogg, and W. M. Thurlbeck (Pathology nstitute, McGill University, Montreal)
Canad. Med. Assoc. J. 99:1128-1133, (Dec. 14), 1968.

A previously healthy young male cadet engaged in shallow-vater scuba "ditching" exercises lost consciousness and died approximately 24 hours later. Having taken a full inspiration at he pool floor, the diver neglected to exhale the expanding ntrapulmonary air while rising to the water surface. In rising rom any depth of water, enclosed air will expand as pressure is educed in accordance with Boyle's law. Under conditions such s those produced by scuba diving, often in the absence of visible ung rupture, very small amounts of air may be forced into he left heart circulation and result in air embolism with serious linical consequences. It is important, with the increasing nterest in scuba diving as a sport, that physicians acquaint hemselves with the physiological changes in diving, the potential azards, and the rationale of therapy.

ASPIRIN—ROSETTA STONE OF GASTROINTESTINAL HEMORRHAGE: A POINT OF VIEW

V. M. Smith and R. R. Babb (Mercy Hospital, Baltimore)
Milit. Med. 133:965-970, (Dec.), 1968.

Among 100 patients with acute gastrointestinal hemorrhage, 94 ad taken a salicylate drug during the 24 hours before the beinning of the hemorrhage. Only seven (14%) of 50 patients in a ontrol group had taken a salicylate drug during the week before dmission to the hospital. The specific bleeding sites of the alicylate-associated hemorrhages were similar to those found in ther reported groups of patients who were studied by early sophagoscopy and gastroscopy. Chronic salicylate users were rare mong the 100 patients. Almost all used salicylates only occasionally and irregularly.

DIETARY PROGRAM TO LOWER SERUM CHOLESTEROL

P. S. Remmell et al. (Harvard School of Public Health, Boston)
J. Amer. Diet Assoc. 54:13-19, (Jan.), 1969.

Observations on the serum cholesterol-lowering response of individuals who formerly participated in the National Diet-Heart Study were made in a two-year follow-up program. Individuals were advised to decrease moderately the consumption of saturated fat and cholesterol and moderately increase polyunsaturated fat intake. Dietary change proved acceptable to a group of healthy middle-aged men receiving proper nutritional information. Dietary change was successfully accomplished by altering patterns of consumption of foods readily and currently found on the market. A modification of dietary fat and cholesterol was beneficial in lowering serum cholesterol levels.

EFFECT OF PREDNISONE ON SURVIVAL OF PATIENTS WITH CIRRHOSIS OF THE LIVER

Copenhagen Study Group for Liver Diseases (N. Tygstrup, Medical Dept. A, Rigshospitalet, Blegdamsvej, Copenhagen)
Lancet 1:119-121, (Jan. 18), 1969.

The survival of 169 prednisone-treated patients with cirrhosis was compared with that of 165 control patients. The death rates were the same in both groups, but among female patients without ascites, the death rate of the prednisone-treated patients was significantly decreased. In patients with ascites, prednisone seemed to increase the death rate. ◄

ESCORT YOURSELF . . .

to Home Lawn Mineral Springs for a few days health vacation —the mineral baths and excellent meals in an atmosphere of serenity will leave your cares behind and play golf on a beautiful course.

HOME LAWN
MINERAL SPRINGS
Martinsville, Indiana

M. C. Pitkin, M.D.
Medical Director

J. W. Gibbs, M.D.
Medical Director
Associate

From *The Journal* 50 Years Ago

When one stops to consider that within the limits of the breadth of the hand laid on the right upper quadrant of the abdomen there may be encompassed localized findings of involvement of about six organs, he is not surprised to find himself in the most interesting zone of abdominal surgical diagnosis. An undescended appendix, the upper pole of the right kidney, the pancreas, the pyloric end of the stomach, the first portion of the duodenum and the gallbladder are here to be reckoned with before an accurate differential diagnosis can be made.

* * *

Unfortunately, there is not as yet any specific test or any method of examination which is pathognomonic for disease of any of these organs, and thus is born the discussion as to what, if any, is the superior method of differentiation. We are not all so fortunate as Moynihan, who claims that the diagnosis of duodenal ulcer is so easy that it can be made by mail. Certain it is that there are many cases of duodenal ulcer that are sufficiently complicated and puzzling that Moynihan or any other good clinician would be very grateful for all the data that could possibly be obtained.

* * *

In discussing the respective virtues of the various methods of diagnosis in duodenal ulcer, W. J. Mayo remarks that, were the means of diagnosis divided into four groups, the history is of first importance, the roentgen ray second, the physical examinations (stomach tube findings, etc.) third, and the purely laboratory findings a poor fourth. The achievements of Dr. Mayo in surgery of the gallbladder and stomach afford telling evidence that, after all, the finger of the trained surgeon inside the belly must often serve as the court of last appeal in unraveling most diagnostic abdominal riddles, for his habit of carefully palpating as many of the viscera as possible in every laparotomy has doubtless served him well in clearing up previously obscure problems . . . . B. P. Weaver, M.D., "Differential Diagnosis Between Lesions of the Gallbladder and Stomach," *JISMA*, July, 1919.

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available

Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

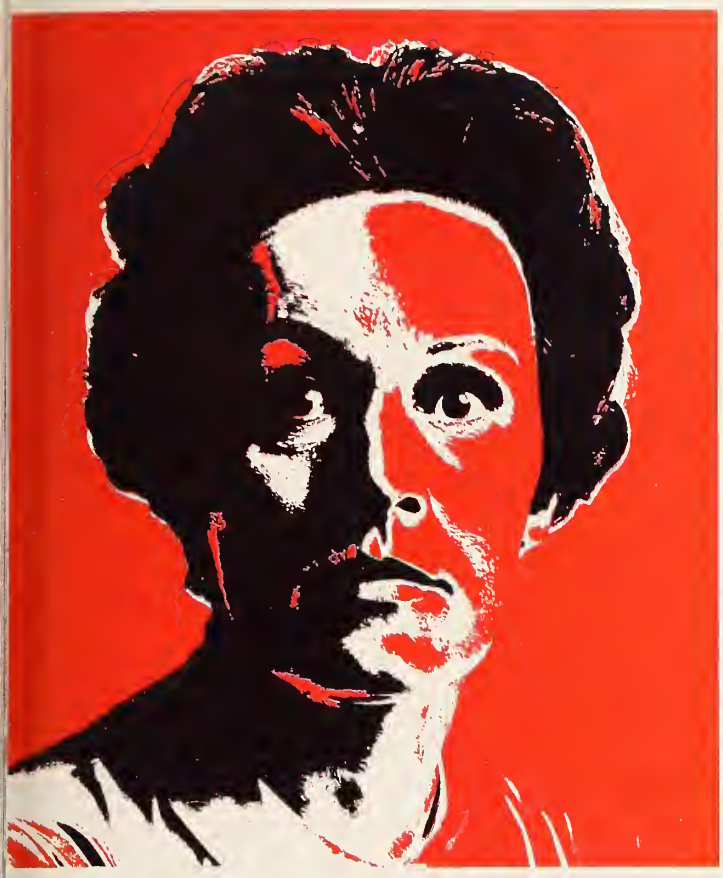
or

Charles W. Neville, Jr., M.D.

Assistant Professor of Psychiatry and Medical Director

Area Code 704-254-3201

In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

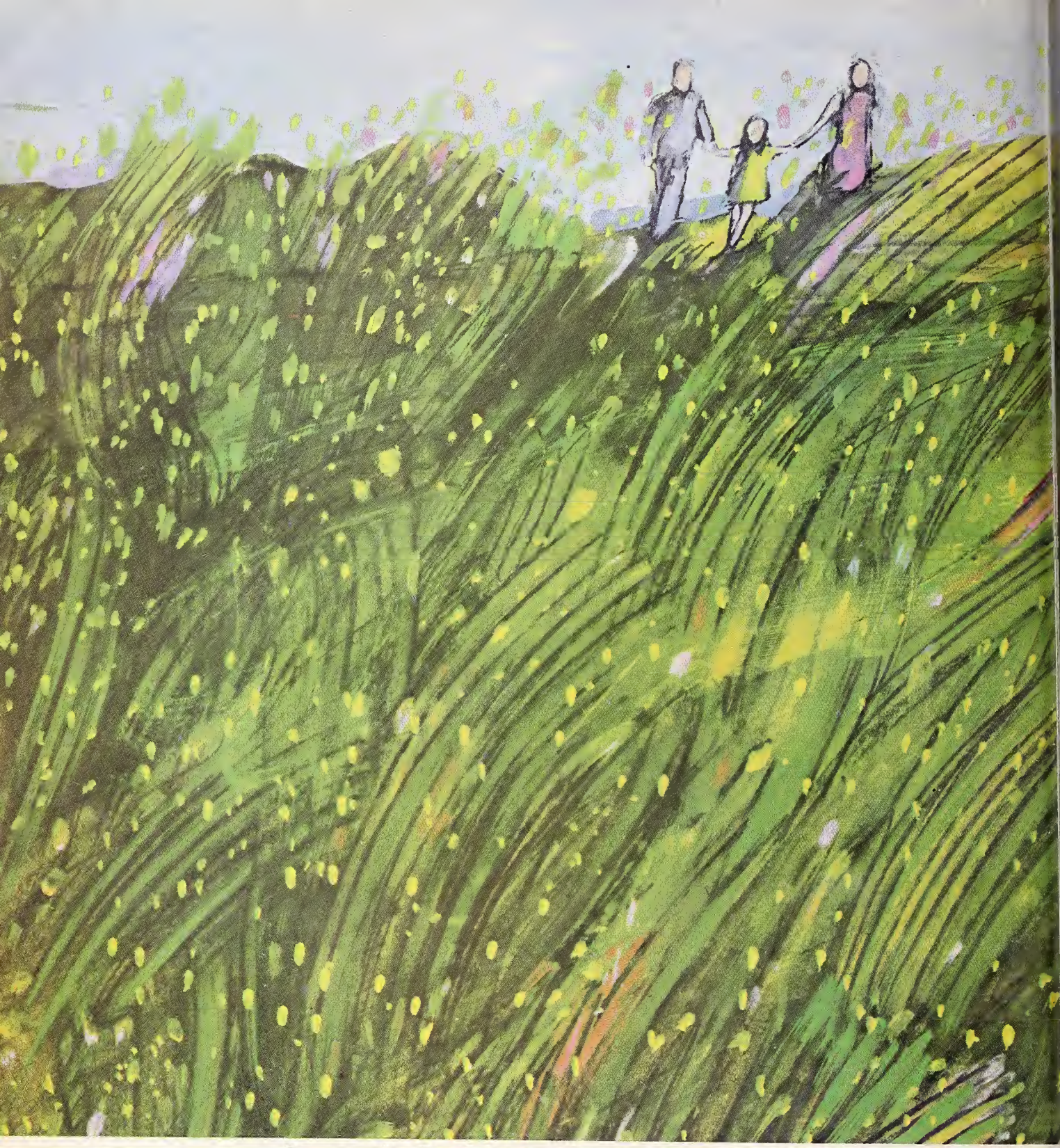
Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-169



...now fast relief of hay fever symptoms with

NTZ®

Nasal Spray



When pollens fly, just one or two squirts of NTZ in each nostril, followed in a few minutes by a second spraying, shrink swollen nasal passages almost on contact. And breathing comfort follows. The antihistamine component of NTZ helps combat the allergic reaction and lessen rhinorrhea, sneezing and itching; its antiseptic wetting agent promotes rapid spread of components.

NTZ Nasal Spray affords the well-known benefits of Neo-Synephrine® in a carefully balanced formula which includes:

Neo-Synephrine® (brand of phenylephrine) HCl, 0.5% (adult strength), decongestant
Thenfadil® (brand of thenyldiamine) HCl, 0.1%, antihistamine
Zephiran® (brand of benzalkonium as chloride, refined) Cl, 1:5000, antiseptic wetting agent

Treatments with NTZ should be repeated every three or four hours as needed. NTZ is for temporary relief of nasal symptoms and overdosage should be avoided. Available in squeeze bottles of 20 ml. and 1 oz. bottles with dropper.

Winthrop Laboratories, New York, N.Y. 10016 (1289M)

When it's more than a bad cold



your patient can feel better while she's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

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now she can cope...



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Butisol SODIUM®

(SODIUM BUTABARBITAL)

the "daytime sedative" for everyday situational stress

When stress is situational—environmental pressure, worry over illness—the treatment often calls for an anxiety-allaying agent which has a prompt and predictable calming action and is remarkably well tolerated. BUTISOL SODIUM (sodium butabarbital) meets this therapeutic need.

After 30 years of clinical use . . . still a first choice among many physicians for dependability, safety and economy in mild to moderate anxiety.

Contraindications: Porphyria or sensitivity to barbiturates.

Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression.

Adverse Reactions: Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.

Warning: May be habit forming.

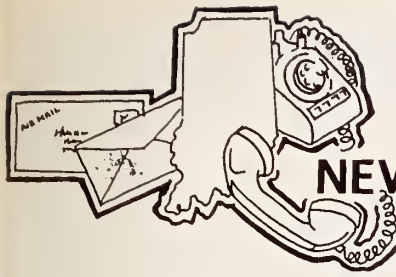
Usual Adult Dosage: As a daytime sedative, 15 mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

Available for daytime sedation: Tablets, 15 mg. (¼ gr.), 30 mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg. (¼ gr.), 30 mg. (½ gr.).

McNEIL

McNeil Laboratories, Inc., Fort Washington, Pa.



NEWS NOTES

Medical Assistants Offered Scholarship Loans for Education

Any qualified young person wishing to pursue a career as a medical assistant may apply for a scholarship loan through the Maxine Williams Scholarship Fund, sponsored by the American Association of Medical Assistants' Endowment. This foundation was established in October, 1968, to administer the scholarship fund.

Participants in the loan program may borrow up to $300 for their education. As a service to the profession, AAMA assumes all administrative costs so there is no interest rate on the loan. If the recipient spends a minimum of two years in the medical assisting field, the loan becomes an outright scholarship, and no repayment is required.

The fund, named in honor of Miss Maxine Williams, AAMA's first president, is supported entirely by private donations from state medical assistant associations as well as local chapters. Contributions are tax deductible as an educational expense.

To be eligible for a loan, one must be a high school graduate who wishes to take formal training in medical assisting. At the present time, AAMA is working with the American Medical Association on an approval program, eventually leading to a standard medical assisting curriculum. The suggested two-year program recommends both administrative and clinical training for an Associate Arts degree at an accredited community or junior college.

Application blanks and information about the Scholarship Loan Fund may be obtained from American Association of Medical Assistants, 200 E. Ohio St., Chicago, Ill. 60611.

Dr. Halfast Named

Dr. Richard W. Halfast, Kokomo, was the featured speaker at a recent March of Dimes organization meeting there.

Dr. Parrish Speaker

Dr. Richard K. Parrish, Decatur, gave a lecture on "Recent Advances in Eye Surgery" recently before the Decatur Rotary Club.

Dr. Bendush on Program

Dr. C. L. Bendush, Evansville, spoke recently at a mini-conference on birth defects sponsored by the Evansville March of Dimes.

PMA Supports Educational and Research Programs with $500,000

The Pharmaceutical Manufacturers Association Foundation announces that it authorized $500,000 during 1968 for the support of research and educational programs. Since the Foundation was organized in 1965, nearly two million dollars have been granted to universities and professional organizations.

Dr. Raymond M. Rice, Indianapolis, is vice president of the Foundation. Dr. Glenn W. Irwin, Jr., Dean of Indiana University School of Medicine, is a member of the Faculty Development Awards in Pharmacology Advisory Committee. Dr. Clyde C. Culbertson, Indianapolis, is a member of the PMA Foundation Fellowship Awards in Pharmacologic-Pathology Advisory Committee.

The PMA Foundation was established to promote the betterment of public health through scientific and medical research, with particular reference to the study and development of the science of therapeutics. The chief areas of interest are the support of fundamental research in drug toxicology, and support of programs of research and training for personnel in clinical pharmacology and drug evaluation.

Dr. Ringer Named

Dr. William A. Ringer, Williamsport, has been elected president of the Fountain-Warren Comprehensive Health Planning Committee. Also elected was Dr. Lee J. Maris, Attica, health officer.

Dr. Swaim Speaks

Dr. J. Franklin Swaim, Rockville, demonstrated a portable electric cardiograph machine and urged the group to consider a health career at a recent combined meeting of the Parke County Junior Heart Board with students at Montezuma and Turkey Run High Schools.

Indianapolis Students Awarded SKF Foreign Fellowships





Nancy Elaine Thompson and Wendell Paul Eicher, both of Indianapolis and both students at Indiana University School of Medicine, have been announced as recipients of Smith Kline and French Foreign Followships. The awards will allow each of them to travel to and obtain supervised medical experience in developing areas overseas.

Miss Thompson will be stationed at the Christian Medical College and Hospital in Vellore, India. Mr. Eicher will serve at the Kamakwie Wesleyan Hospital at Sierra Leone, West Africa. Twenty-nine other students from other American medical schools received similar fellowships this year.

In ten years, Smith Kline and French Laboratories have awarded 308 fellowships for work and study in more than 50 countries of Africa, Asia, Latin America and Oceania.

VA Hospital Remodeling

Three wing sections of the Indianapolis Veterans Administration Hospital will be remodeled this summer at a cost in excess of $220,000, for the establishment of intensive care units. Two of the units will have 10 beds each for medical and surgical patients. The third will be an eight-bed coronary care unit.

Continued



The Fortunate One.

Her urinary tract infection reveals itself through pain and discomfort.

While the pain and discomfort of a G.U. infection are anything but pleasant, the patient may be luckier than she realizes. That burning sensation (and/or frequency, urgency, dysuria) is a usually reliable sign of a urinary tract infection. And it's her good fortune that her infection won't go undetected...or untreated.

Azo Gantanol® therapy usually provides analgesic action within one-half hour, while control of the infection begins within two hours. Azo, a specific urinary analgesic, soothes inflamed mucosa to give symptomatic relief. At the same time, the antibacterial component, Gantanol (sulfamethoxazole), achieves therapeutic levels in the blood and urine, with diffusion into interstitial fluids. Azo Gantanol—a good choice when urinary tract infection reveals itself through symptomatic distress.

Before prescribing, please consult complete product information, a summary of which appears on opposite page.

Azo Gantanol®

(Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.)

Azo for the pain
Gantanol®
(sulfamethoxazole)
for the pathogens

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Urinary tract infections with associated pain or discomfort when due to susceptible organisms; prophylactically in urologic surgery, catheterization and instrumentation.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, newborn infants during the first three months of life, glomerular nephritis, severe hepatitis, uremia and pyelonephritis of pregnancy with gastrointestinal disturbances.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

Adverse Reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

Dosage: Adults—4 tablets initially, then 2 tablets morning and evening.

How Supplied: Tablets, bottles of 50.



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LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

NEWS NOTES

Continued

Dr. Acher is Speaker

Dr. Robert P. Acher, Greensburg, was the speaker recently at the annual meeting of the Hancock County Association for Mental Health.

Symposium Speakers

A "Symposium on Water and Electrolyte Balance," which was conducted in May at the Gary Methodist Hospital, was attended by over 60 physicians. **Dr. W. P. Loh** moderated the program which was given by **Drs. Harry F. Weisberg, Lucien A. Lewis, Jack M. Kamen, Robert J. Milos and Dr. Loh.**

Dr. Peare Elected

Dr. Reeve B. Peare, Huntington, has been elected vice-president of the Huntington County Association for Retarded Children.

Dr. Rohn is Speaker

Dr. Robert J. Rohn, Indianapolis, spoke on "Adult Leukemia and Lymphoma" at a recent meeting of the Eighth District Chapter of the Indiana Academy of General Practice.

Cardiology Speaker

Dr. Harvey Feigenbaum, Indianapolis, addressed St. Mary Hospital's medical staff and other Tri-State physicians recently at Evansville on "Ultrasound Diagnosis in Cardiology."

Dr. Ball Honored

Dr. Clay A. Ball, practicing Muncie physician for more than half a century, was honored recently by Muncie Rotarians on his 91st birthday celebration. Dr. Ball received a standing ovation from the group.

On Health Panel

A panel discussion was one of the highlights of the Mental Health Community Workshop held recently in the Scottsburg High School. The panel featured **Dr. Phillip Holmes,** psychiatrist at Madison State Hospital and **Dr. Howard Jackson,** Madison general practitioner.

Speakers at Meeting

Drs. Don Boyer, C. G. Kern and James R. McAfee, all of Lebanon, explained new x-ray equipment designed to improve and speed up diagnosis of respiratory diseases at a recent board of directors meeting of the Boone County Tuberculosis Association.

Mead Johnson Laboratories Announces New Calcium Product

U. S. Department of Agriculture studies indicate that calcium with its high daily requirement is one of the nutrients most often deficient in American diets.

Mead Johnson Laboratories has announced a new product, SPAR-CAL, which makes calcium—and the vitamin D necessary for its absorption and utilization—available in a pleasant-tasting form.

The orange-flavored, effervescent tablet dissolves quickly in six ounces of water and provides 500 mg. of elemental calcium

Continued

NEWS NOTES

Continued

(66% of MDR) and 200 USP units of vitamin D.

SPAR-CAL is indicated in calcium deficient diets, in pregnancy, during periods of rapid growth and in allergy or dislike of milk.

Dr. Haggard Retires

Dr. E. B. Haggard, Indianapolis, has retired from the practice of medicine. He has been chief medical consultant for the Social Security Disability program for the past 14 years.

Dr. Tischer Leaves

Dr. E. Paul Tischer, Indianapolis, has begun the practice of medicine in Richland Center, Wisconsin with the Richland Medical Center, Inc. Dr. Tischer had offices in the Hume Mansur Building for many years.

New Officers Named

Dr. Charles Rushmore, Indianapolis, is the newly elected president of the Indiana Public Health Association, Inc. He will serve until March 31, 1970.

Dr. Grosz is Speaker

Dr. Hanus J. Grosz, Indianapolis, recently demonstrated self-help and group therapy technics for mentally disturbed patients.

Members of a group known as Recovery, Incorporated, each one a psychoneurotic or a former mental patient, presented a program before the American Psychiatric Association at Miami. Dr. Grosz introduced the group and sponsored the program.

Recovery, Inc., was started 30 years ago to maximize the amount of help which neurotic or mentally disturbed patients can obtain from within themselves and from their organization.

Physicians Take Cruise

Dr. and Mrs. John T. Embardt, Dr. and Mrs. Louis T. Need, and Dr. and Mrs. Lester D. Bibler recently returned from a Mediterranean cruise. They visited Athens, Greece, and Istanbul, Turkey among many interesting places.

Dr. Poncher Speaks

Dr. John R. Poncher, Valparaiso pediatrician, talked on the subject of sex education at a recent meeting of the Welcome Wagon Club of Valparaiso.

Speaks on Effects of Alcohol

Medical analysis relating to the use of alcohol was presented by **Dr. James Miller, Greensburg,** at a meeting of the Greensburg Kiwanians recently. Dr. Miller centered his remarks on the effects of alcohol on the human body.

ABWA Hears Physician

Dr. James L. Doenges, Anderson, was guest speaker recently at a meeting of the Harvest Moon chapter of the American Business Women's Association.

Kilmer Prize Awarded

Bruce H. Mock, a senior in the School of Pharmacy at Purdue University and a resident of South Bend, has received the American Pharmaceutical Association Kilmer prize for the best pharmacognosy research paper by a student of a graduating class in any accredited school of pharmacy.

Lilly Promotions Announced

Mr. Eli Lilly has been elected honorary chairman of the boar and Eugene N. Beesley, president of the company since 1953, now chairman of the board of Eli Lilly & Company. Burton l Beck has moved from executive vice-president to president.

Stuart Representative Named

Ivan W. Beyeler has been assigned to the Fort Wayne territor as a representative of Stuart Pharmaceuticals. His territory in cludes Wabash and Warsaw and extends to the Michigan lin and to Lima, Ohio. Mr. Beyeler is a 1968 graduate of Goshe College.

New Manual on Arthritis Home Care Now Available

Publication of a new booklet which tells arthritis patients hov they can prevent deformity was announced today by Th Arthritis Foundation.

Titled "Home Care Programs in Arthritis—A Manual fo Patients," the 24-page illustrated booklet was prepared by mem bers of the Allied Health Professions Section of the Foundatior It will be offered by local chapters of the Foundation, at no cos to physicians who in turn may pass it on to their patients a a supplement to the treatment they prescribe.

Surgeon is Speaker

Dr. Ara V. Dumanian, Homewood, Ill., was guest speake recently at a dinner meeting of the Whiting Science Club. Hi topic was "Heart Transplants and Coronary Artery Surgery." Dr Dumanian is a specialist in chest and heart surgery at St Catherine's Hospital, Hammond.

Dr. Green Appointed

Dr. Morris Green, Indianapolis, has been appointed chair man of the American Academy of Pediatrics' section on chil development. Dr. Green is chairman of the Diagnostic and Out patient Center of James Whitcomb Riley Hospital for Childre at the I.U. Medical Center.

Speaker at Meeting

Dr. S. E. McClure, Monon, discussed the problem of birth defects in White County at the annual "pre-campaign" dinne meeting of the White County Chapter of the National Foundatio —March of Dimes.

New SK&F Medical Film Now Available to Physicians

A new medical film "Recognition of Narcotic Withdrawal Symp toms in Newborn Infants" is now available from Smith Kline French Laboratories. It is a 16 mm color film, runs for si minutes, and shows a physician comparing the responses o addicted and non-addicted infants. It may be borrowed free o charge from the SK&F film center at 1500 Spring Garden St Philadelphia 19101.

Booklet on Drug Abuse Available from Blue Shield

An extremely well done booklet on drug abuse titled "Dru Abuse: The Chemical Cop-Out" has been published by Th National Association of Blue Shield Plans. The publication wa devised on the obviously correct principle that the more goo

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Dulcolax®...so predictable you can almost set patients by it.

Dulcolax works so effectively that the time of bowel evacuation can often be predicted.

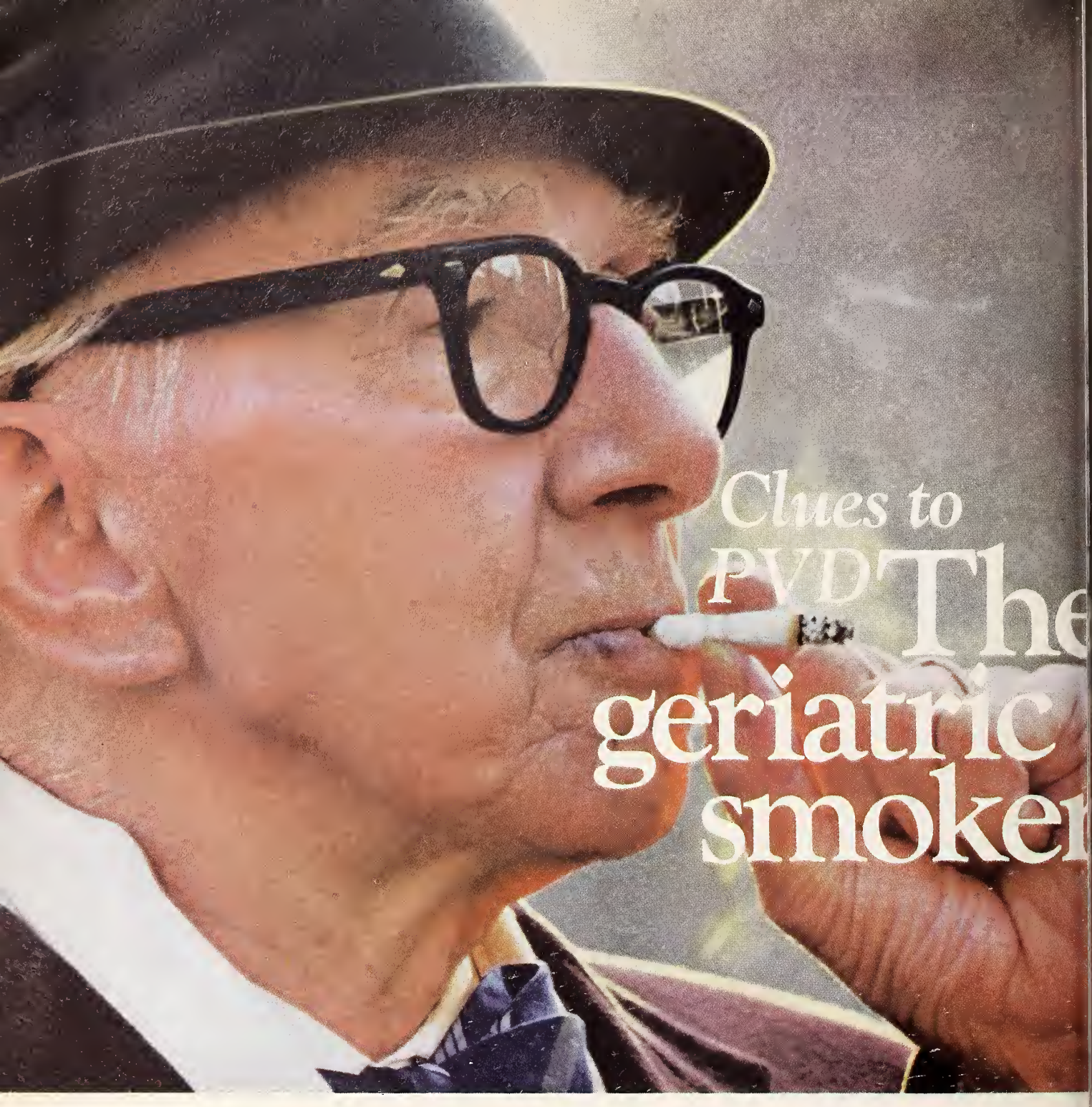
Dulcolax tablets taken at night will usually result in a convenient bowel movement the following morning. Dulcolax suppositories generally work within 15 minutes to an hour.

Dulcolax may be given to the aged, pregnant or nursing women, and children. It may be particularly helpful in conditions in which straining should be avoided. The drug, however, is contraindicated in the acute surgical abdomen.

Dulcolax® bisacodyl



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Clues to PVD The geriatric smoker

In studies on peripheral vascular disease—a common by-product of the degenerative aging process—considerable attention has focused on the important role of smoking in the progression of the disease. Although it may not be etiologic, smoking is widely recognized as a prominent contributing factor.[1]

Skin blood flow—significant factor in PVD. Cutaneous digital vasoconstriction caused by nicotine has been observed both in normal subjects and in patients with peripheral vascular disorders.[1,2] Among patients with peripheral vascular disease, however, age and the severity of the disease appear to modify the effects of nicotine. For example, in a study of older patients with *marked* peripheral vascular disease,[3] changes induced by smoking were not statistically significant for the group as a whole. This was explained on the basis of decreased skin reactivity. *Smoking is not permissible in any stage of the disease,* since even "... minimal reduction in blood flow in patients with ischemic limbs may produce a further reduction in tissue nutrition, and thu may be another case of the proverbial straw on th camel's back."[3]

In another study of patients with peripheral vascula disease,[4] the investigators stress that decreased skin bloo flow during smoking "... is the factor of most importanc to the patient with peripheral vascular disease." *Whi such patients may adjust to the discomfort of vascular i sufficiency in skeletal muscle, decreased skin blood flow ma often lead to severe symptomatology.*

More and more physicians have adopted the practic of investigating for peripheral vascular disorder whe confronted with a geriatric patient who is a habitua smoker. Once a diagnosis is established, therapeut measures are directed toward increasing the peripher circulation and appropriate management of the patient general medical needs. These include the importar safeguards of keeping warm and refraining from smokin

Professional model posed for illustration.

mportant in
otal management of
peripheral vascular disease,
vascular spasm or
chilblains

Roniacol®
Timespan®
(nicotinyl alcohol tartrate)

for relief of ischemic symptoms

onvenience of b.i.d. dosage—sustained-release Timespan Tablets usually provide olonged relief of ischemic symptoms with two doses daily.
noothness of onset—the action of Roniacol (nicotinyl alcohol) is smooth and gradual onset, rarely causing severe flushing.
lectivity of action—relaxes the musculature of peripheral blood vessels.
igh degree of safety—side effects seldom require discontinuation of therapy.

efore prescribing, please consult complete product information, a summary of which follows:
dications: Conditions associated with deficient circulation; *e.g.*, peripheral vascular disease, vascular spasm, ricose ulcers, decubital ulcers, chilblains, Meniere's syndrome and vertigo.
aution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.
de Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, dom requiring discontinuation of the drug.
osage: 1 or 2 Timespan Tablets morning and night.
ow Supplied: Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt, bottles of 50.

eferences: (1) Roth, G. M.; Shick, R. M., and Secrest, R. R., in James, G., and Rosenthal, T., s.: *Tobacco and Health*, Springfield, Ill., Charles C Thomas, 1962, pp. 311-322. (2) Entmacher, P. S.: oc. Med. Sect. Amer. Life Convention *51*:149, 1963. (3) Freund, J., and Ward, C.: Ann. New York Acad. i. 90:85, 1960. (4) Coffman, J. D., and Javett, S. L.: Circulation 28:932, 1963.

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"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.



Continued

information on the subject is available and disseminated, the quicker the teenage drug problem will be solved. Blue Shield is distributing the booklet as a part of a public information program. Contact your local Blue Shield office.

Dr. Dyken is Speaker

Dr. Mark L. Dyken discussed "Emergency Treatment of Stroke" at a meeting for physicians recently in the Fort Wayne Veterans Administration Hospital. Dr. Dyken is attending physician in neurology for the Indianapolis Veterans Administration Hospital.

Dr. Khalouf Speaks

Dr. Shirley Khalouf, member of the Marion General Hospital staff, discussed "Rehabilitation" at a recent meeting of the Grant County Retired Teachers Association.

Dr. Keenan on Panel

Dr. George B. Keenan, Indianapolis, joined with three other Indianapolis professional men recently on a panel to extol the benefits of Boys Club membership at a dinner meeting of the Boys Club Alumni Association.

Dr. Holtzman Named

Dr. Paul W. Holtzman, Bloomington, has been elected chief of staff of the Bloomington Hospital.

Chief of staff-elect for the coming year will be **Dr. I. Taylor Rieger.** Chosen for the office of secretary-treasurer was **Dr. Glen D. Ley.**

Dr. Brad Bomba is the new chief of medicine and **Dr. Richard Schilling,** chief of surgery. **Dr. Frank Hrisomalos** will assume the duties of secretary for the medical section of the staff and **Dr. Michael Surian** will be the surgical section secretary.

Elected directors-at-large for the executive committee of the staff were **Dr. Glenn B. Mather** and **Dr. James Farr.**

New Officers

Officers of St. Joseph's Hospital Staff, Fort Wayne, have been elected. The officers are: **Dr. Louis Schneider,** president; **Dr. John E. Krueger,** president-elect and **Dr. Charles Giffin,** secretary-treasurer.

Dr. Kelsey is Speaker

Dr. Robert M. Kelsey, LaPorte, spoke on the effect of drug use by youth at a recent meeting at St. Joseph's School there.

American College of Emergency Physicians Seek New Members

The increasing patient loads in emergency departments across the country has underscored the need for a new type of physician —a specialist in emergencies: the emergency physician. To assist this new breed of physicians the American College of Emergency Physicians was organized in August, 1968.

A nucleus of physicians—both from full-time and part-time emergency care groups in Michigan—chartered the American College of Emergency Physicians and have organized the college on a nationwide basis.

At a meeting in Chicago in February, 1969, further steps were taken to widen the scope of the new specialty group. Representatives from 19 states were present to help plan the future of the college.

One of the main purposes of the college is to improve emergency services rendered to the patient. Other aims of the college are: to encourage and implement the training and continuing education of emergency physicians; to promote policy which preserves the integrity of private practice; to promote coordination of community emergency care facilities and personnel; to advance the ethical standards of the private practice of emergency medicine and surgery.

The first and most important order of business is to attract those physicians who are working, full-time or part-time, in emergency departments across the country. For information write: Executive Secretary, American College of Emergency Physicians, 120 W. Saginaw St., East Lansing 48823; or the representative in your area: E. W. Donelan, M.D., 2425 South Glenwood, Springfield, Illinois 62704.

Dr. Parrish Speaks

"Recent Advances in Eye Surgery" was the topic chosen by **Dr. Richard K. Parrish, Decatur,** when he spoke recently before the Decatur Rotary Club.

Dr. Wagner Appointed

Dr. David G. Wagner, Goshen, has been appointed deputy coroner by coroner-elect Frederick W. Bigler. Dr. Wagner is an anesthetist at Goshen Hospital.

Dr. Dragoo Named

Dr. John R. Dragoo, Wabash, has been appointed to the board of directors of the Frances Slocum Bank and Trust Company, Wabash.

Pitman-Moore Veterinary Line Sold to Johnson & Johnson

The Pitman-Moore line of ethical veterinary products has become a part of Johnson & Johnson, pharmaceutical manufacturers of New Brunswick, New Jersey. The sale by Dow Chemical Company includes the trade name "Pitman-Moore."

The facilities at Indianapolis and Zionsville will continue to produce human health care products under a new name, yet to be selected. Pitman-Moore will produce veterinary products for Johnson & Johnson until facilities can be arranged in New Jersey.

Dr. Stephens Renamed Chief

Dr. Donald E. Stephens, Indianapolis, has been re-elected president of the Methodist Hospital medical staff for 1969. **Dr. John H. O. Mertz** was elected vice-president and **Dr. B. T. Maxam,** secretary-treasurer.

Dr. Caylor Named

Dr. Charles H. Caylor, Bluffton, has been elected a director of the Old First National Bank there.

Dr. Klepinger Elected

Dr. Harry E. Klepinger, Lafayette, has been named to a second term on the Indiana Air Pollution Control Board.

Disease Detection Information Bureau Completes First Year

The Disease Detection Information Bureau (DDib) has just completed its first year of service. It is supported by the Ames

Continued

Continued

Company of Elkhart to serve as a source for informational and educational materials in a number of different disease conditions which can be detected through medically approved screening programs. Its initial work is in connection with diabetes. DDib will aid any community in conducting a diabetes detection program. A "how-to-do-it" campaign manual and a kit are available. Information may be obtained by writing DDib at 3553 W. Peterson Ave., Chicago 60645.

Dr. Byllesby Certified

Dr. Joyce E. Byllesby, Crawfordsville, pathologist at Culver Hospital, has been certified by the American Board of Pathology.



That sneaky Dr. Dabbs is moving his office uptown, leaving us to have to take care of ALL the aches and pains in this area!

Dr. Dietz Elected

Dr. David J. Dietz, Muncie, has been re-elected president of the Delaware County Cancer Society (Little Red Door).

Dr. Phillips Gets Grant

Dr. John F. Phillips, chief of cardiology at the Caylor-Nickel Clinic in Bluffton, has received a $5,000 grant from the Northeast Indiana Heart Association for a study on "Creatine Metabolism in Myocardial Infarction."

Staff Officers Elected

Dr. Joseph C. Kerlin, Danville, has been elected chief of staff for 1969 of the Hendricks County Hospital. Other officers elected were: **Drs. Thomas Walker, Brownsburg,** vice-president and **Robert Kirtley, Danville,** secretary-treasurer.

Dr. Encinas Named

Dr. Senen J. Encinas, English, has been named county health officer for a term of four years. Dr. Encinas is resident physician at the Crawford Medical Clinic.

Dr. Sixbey Elected

Dr. Maurice Sixbey, Denver, has been elected chief of staff of Dukes Hospital for 1969. Other officers include: **Drs. J. U. Guthrie, Peru,** vice-president and **H. E. Rendel, Peru,** secretary.

Doctors Honored

Drs. William H. Hutto and **Richard P. Good, Kokomo,** recently received 30-year service certificates at the eighth annual banquet for the medical staff of St. Joseph Memorial Hospital.

Officer Named

Dr. Max N. Hoffman, Covington, has been named president of the medical staff at St. Elizabeth Hospital in Danville, Ill.

Dr. Hardtke Speaks

Dr. Eldred F. Hardtke, Bloomington, spoke on "Women's Tensions and How to Cope With Them" at a recent meeting of the University Newcomers in Bloomington.

Dr. Parke is Speaker

Dr. William C. Parke, Warsaw, was guest speaker recently for the Lamplighters Sunday School Class meeting at the Warsaw Trinity United Methodist Church. Dr. Parke showed slides of Panama taken during a recent Methodist-sponsored mission trip.

Dr. Wilson Named

Dr. John Wilson, Columbia City, has been named to a four-year term on the Whitley County Health Board.

Dr. Lindauer Takes Course

Dr. David H. Lindauer, Princeton, recently attended a graduate course for instructors of external cardiopulmonary resuscitation presented in Indianapolis by the Indiana Heart Association and the Methodist Hospital Graduate Medical Center. ◄

Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION ANNUAL CONVENTION
Date July 13-17, 1969
Place New York, N. Y.

INDIANA DENTAL ASSOCIATION
Date May 13-16, 1970
Place Indianapolis Hilton Hotel, Indianapolis

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 13-16, 1969
Place Indianapolis

ORTHERN INDIANA SYCHIATRIC SOCIETY
ate Fourth Wednesday of every month, September through June
lace For location and program, inquire Beatty Memorial Hospital, Westville

INDIANA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS
Date May 6-7, 1970
Place Stouffer's Inn, Indianapolis

INDIANA HOSPITAL ASSOCIATION
Date October 15-17, 1969
Place Center for Continuing Education, University of Notre Dame, South Bend

NDIANA ROENTGEN SOCIETY, INC.
ate March 1, 1970
lace Holiday Inn East, Indianapolis

BONE AND JOINT CLUB
Date October 22, 1969
Place The Athenaeum, Indianapolis

INDIANA STATE NURSES ASSOCIATION
Date October 16-18, 1969
Place Civic Auditorium, Evansville

INDIANA SOCIETY OF ANESTHESIOLOGISTS
Date May 23, 1970
Place Marott Hotel, Indianapolis

NDIANA ACADEMY OF GENERAL RACTICE
ate April 14-16, 1970
lace Indianapolis

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date May 6-8, 1970
Place Morris Inn, South Bend

INDIANA ASSOCIATION OF PATHOLOGISTS
Date December 6, 1969
Place Indianapolis Motor Speedway Motel, Indianapolis

INDIANA MEDICAL BUREAU
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FUTURE MEETINGS, SEMINARS, COURSES

Laboratory Animal Science Annual Session October 13-17

The American Association of Laboratory Animal Science will conduct its annual session in Dallas from October 13 to 17.

Research scientists, laboratory animal technicians and members of related trade groups from United States and Canada will attend. About 2,000 persons are expected.

The program contains over 100 original papers. There will also be a series of basic animal care lectures and a series of seminars. AALAS headquarters are at 4 E. Clinton St., Joliet, Illinois 60434.

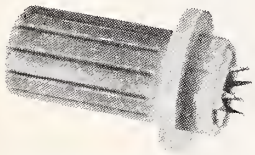
General Practice Review Set By University of Colorado

A General Practice Review will be conducted as postgraduate medical education by the University of Colorado at Denver on August 11 to 16.

Each day of the week starting with Monday will be concerned with subjects in Medicine, Pediatrics, Dermatology, Surgery, Obstetrics and Gynecology, and Trauma. For more detail write Postgraduate Medical Education, 4200 E Ninth Ave., Denver 80220.

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



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(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

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Postgraduate Course in Internal Medicine Offered

The University of Colorado School of Medicine will conduct a postgraduate course in internal medicine at Estes Park from July 21 to 25. Another course in Pediatrics will be at Aspen from August 3 to 6. For further details write in care of 4200 E. Ninth Ave., Denver 80220.

Kidney Foundation of Illinois Conducts Fifth Annual Symposium

The Kidney Foundation of Illinois will conduct its Fifth Annual Symposium on Recent Advances in Renal Disease at the LaSalle Hotel in Chicago on Wednesday, October 15, from 9 AM to 5 PM. For more information write the Executive Director, Hayes Beall at 127 N. Dearborn St., Suite 701, Chicago 60602.

Cleveland Course in Pulmonary Diseases Will Be September 24-26

The Cleveland Course in Pulmonary Diseases will be conducted at St. Luke's Hospital on Shaker Boulevard in Cleveland on September 24, 25, and 26.

The program will be oriented on "The Clinical Application of Pulmonary Physiology." The registration fee is $75 for members of the American Thoracic Society and $100 for non-members.

For complete details write the Office of Continuing Medical Education, Case Western Reserve University School of Medicine, 2107 Adelbert Road, Cleveland 44106.

16th Western Cardiac Conference October 22-24 in Denver, Colorado

The 16th Western Cardiac Conference of the University of Colorado Medical Center will be conducted on October 22, 23 and 24 at the Denison Auditorium in Denver.

A distinguished guest faculty will conduct the program. Write the Colorado Heart Association, 1375 Delaware St., Denver 80204 for further information.

AMA Congress on Occupational Health in St. Louis in September

The AMA Congress on Occupational Health will be held in St. Louis on September 15 and 16, at Stouffer's Riverfront Inn.

Indiana is represented by Dr. Neal Baxter of Bloomington who is a member of the Council on Occupational Health, by Edna Watson, R.N., of Anderson who will participate in a symposium on the nurse's role in pre-placement examination, and by Dr. David Joe Smith, formerly of Indianapolis and now from Pittsburgh, who will speak on the subject "Absenteeism and 'Presenteeism' in Industry." A block of rooms is reserved for those who wish to attend. There is no registration fee. AAGP credit is 10½ hours. ◄

County, District News

First District

The First District Medical Society has elected the following as new officers: Drs. James L. Hobgood, Evansville, president; Fred Smith, Tell City, vice-president and Ray H. Burnikel, Evansville, secretary-treasurer.

Second District

Dr. Thomas O. Barrett has been elected president of the Second District Medical Society and Dr. J. S. Brown, Carlisle, was elected secretary for the 47th time. Dr. Joe Dukes, Dugger, was re-elected trustee to succeed himself.

Third District

New officers of the Third District Medical Society are: Drs. Daniel H. Cannon, New Albany, president and Elmer L. Wallace, New Albany, secretary-treasurer. The next meeting will be held at New Albany April 1st, 1970.

Fourth District

The Fourth District Medical Society officers for 1970 will be: Drs. D. D. Dickson, Greensburg, president and Dr. James C. Miller, Greensburg, secretary-treasurer. Dr. Joe Black, Seymour, was re-elected to the Blue Shield Board.

Fifth District

Newly-elected president of the Fifth District Medical Society is Dr. William R. Tipton, Greencastle. Dr. Cleon M. Schauwecker, Greencastle, was elected secretary-treasurer and Dr. Wilbert McIntosh, Riley, was re-elected trustee.

Sixth District

Dr. Perry F. Seal, Brookville was elected president; Dr. David E. Wynegar, Richmond, vice-president and Dr. Mark Smith, New Castle, secretary-treasurer of the Sixth District Medical Society for the ensuing year. Dr. Wynegar was also elected alternate trustee.

Seventh District

The Seventh District Medical Society officers for the coming year are: Drs. Malcolm O. Scamahorn, Pittsboro, president; Ellery T. Drake, Martinsville, president-elect and Donald E. Stephens, Indianapolis, secretary-treasurer. Dr. John Butler, Indianapolis, was re-elected alternate trustee and Dr. Glen V. Ryan, Indianapolis, was re-elected to the Blue Shield Board.

Ninth District

The Ninth District Medical Society met in May to hear the Hon. Richard Roudebush, Congressman from the Fifth District, speak. Entertainment was provided by the Purdue Civic Chorus.

Twelfth District

Officers of the Twelfth District Medical Society for 1970 will be: Drs. John J. Hartman, Angola, president; J. Robert Edwards, Auburn, vice-president; DeWayne L. Hull, Fort Wayne, secretary-treasurer and Kenneth F. Isenogle, Fort Wayne, Blue Shield Board member. The 1970 meeting will be May 20th at Fort Wayne.

Bartholomew-Brown

The Bartholomew-Brown County Medical Society met April 9 to see a film on cardiopulmonary resuscitation and elect new officers. Dr. Thomas P. Dugan, Columbus, is president; Dr. K. D. Schneider, Columbus, president-elect; Dr. C. D. Ryan, Columbus, secretary-treasurer; Drs. Robert M. Seibel, Nashville and Harold W. Richmond, Columbus, delegates and Dr. Walter Able, Columbus, alternate delegate.

Boone

Field Secretary Howard Grindstaff met May 6 with the Boone County Medical Society to report on the legislative session.

Dearborn-Ohio

Dr. Charles Blase, of Cincinnati, spoke on ENT carcinoma at the May 1 meeting of the Dearborn-Ohio County Medical Society.

Decatur

New officers of the Decatur County Medical Society are: Drs. James C. Miller, Greensburg and Alfredo Paje, Greensburg, secretary-treasurer. Delegate will be Dr. Robert Acher, Greensburg and alternate delegate will be Dr. Miller.

DeKalb

Dr. W. B. Hughes, Waterloo, is the new president; Dr. C. Bishop Hathaway, Auburn, the new vice-president and Dr. Benjamin R. Graber, Waterloo, the new secretary-treasurer of the DeKalb County Medical Society.

Elkhart

Dr. David Vidt of the Cleveland Clinic spoke at the May 1 meeting of the Elkhart County Medical Society. His topic was "Current Status of Renal Transplants."

Fort Wayne

Current officers of the Fort Wayne Medical Society are: Drs. Maurice E. Glock, president; Jerry L. Stucky, president-elect; Eugene E. Schmidt, secretary and Robert J. Voorhees, treasurer.

Harrison-Crawford

The Harrison-Crawford County Medical Society has elected the following as officers for 1970: Drs. David Dukes, president; Richard Jordan, vice-president and Samuel W. Martin, secretary-treasurer. All of the new officers are from Corydon.

Noble

Dr. Max Sneary, Avilla, is the new president and Dr. J. A. Greenlee, Avilla, the new secretary-treasurer of the Noble County Medical Society.

Parke-Vermillion

Dr. Frederick J. Evans, Clinton has been elected president and Dr. William G. Minich, Rockville, secretary-treasurer of the Parke-Vermillion County Medical Society.

Perry

Field Secretary Robert Amick visited the May 12 meeting of the Perry County Medical Society to report on the legislative session.

St. Joseph

Election of new officers of the St. Joseph County Medical Society resulted in the following: Drs. R. H. Denham, president; Logan Dunlap, president-elect; and Eldred MacDonnell, secretary-treasurer.

Tippecanoe

Kirby Risk of the United Fund and Field Secretary Howard Grindstaff spoke at the May 13 meeting of the Tippecanoe County Medical Society.

Wabash

New officers of the Wabash County Medical Society are: Drs. Stanley Zydlo, Wabash, president; Frank Smyrniotis, Wabash, vice-president and R. B. Mernitz, Wabash, secretary-treasurer. ◄

Deaths

Guy D. Baker, M.D.

Dr. Guy D. Baker, 82, practicing physician in Crandall and Georgetown for nearly 60 years, died April 25.

Graduated from the University of Louisville School of Medicine in 1910, Dr. Baker had practiced medicine in Crandall from 1913 until last year, when he became ill. He was a physician at Georgetown from 1910 to 1913. He was a director of the Harrison County Bank, and was that bank's first president. He was also a former president of the Harrison-Crawford County Medical Society and former chairman of the Floyd-Harrison County Health Department.

John H. Baldwin, M.D.

Dr. John H. Baldwin, Jeffersonville physician for more than 50 years, died April 7 at the age of 92.

A native of New Albany and a graduate of Southwestern Homeopathic Medical College at Louisville, Dr. Baldwin began his practice in Jeffersonville in 1898. He retired in 1948. Dr. Baldwin twice served as city health officer, was a Senior Member of ISMA, member of the ISMA 50-Year Club and the Clark County Medical Society.

Claude M. Donahue, M.D.

Dr. Claude M. Donahue, Carmel physician and Hamilton County coroner, died May 19 at his home. He was 73.

Dr. Donahue went to Carmel in 1927, after being graduated from the I.U. School of Medicine. During World War I, he served in the Navy as an ensign in charge of a sub-chaser in the waters off Norfolk, Va. Dr. Donahue was a champion trap shooter, and won a trophy the day before his death, hitting 98 out of 100 targets. He ranked as one of the top four trap shooters in the nation. On the staff of Riverview Hospital, Noblesville, Dr. Donahue was a member of the Hamilton County Medical Society.

John L. Glendening, M.D.

Dr. John L. Glendening, 85, a pediatrician in Indianapolis for more than 30 years, died April 18 in an Indianapolis nursing home.

Born at Washington, Indiana, Dr. Glendening was graduated from the I.U. School of Medicine in 1917. He was a member of the Army Medical Corps in World War I, a Senior Member of ISMA, a member of the 50-Year Club and the Marion County Medical Society.

Lloyd J. Holladay, M.D.

Dr. Lloyd J. Holladay, Jefferson High School athletic team physician for over 20 years, died April 13 at the age of 65.

Graduated from the I.U. School of Medicine in 1933, Dr. Holladay went to Lafayette that same year to set up his practice. He also was surgeon and physician for the firemen and policemen in Lafayette for many years. Formerly chief of staff at St. Elizabeth Hospital and a member of the welfare board, Dr. Holladay was serving as chairman of the Indiana State Athletic Commission at the time of his death. He was a member of the Tippecanoe County Medical Society.

Walter F. Kammer, M.D.

Dr. Walter F. Kammer, Muncie cardiologist, died May 10 while skiing in the French Alps. He was 56 years old.

A cardiologist at Ball Memorial Hospital since 1946, Dr. Kammer was also a specialist in internal medicine at the Muncie Clinic. He was graduated from Rush Medical College in 1938 and was a member of the Delaware-Blackford County Medical Society.

Theodore D. Rhodes, M.D.

Dr. Theodore D. Rhodes, 68-year-old dermatologist, died May 13 in Sarasota, Fla., where he had moved approximately 15 years ago.

Dr. Rhodes, who was graduated from the I.U. School of Medicine in 1925, practiced dermatology in Indianapolis for more than 20 years. A native of Peru, Ind., he practiced in the Hume Mansur Building from 1931 until his retirement in 1953. He was a member of the Marion County Medical Society.

Gerald H. Somers, M.D.

Dr. Gerald H. Somers, Fort Wayne general practitioner, died May 14 in Sarasota, Fla., where he had been vacationing. He was 58 years old.

Born in Ossian, Dr. Somers was graduated from the I.U. School of Medicine in 1937 and began his practice in Fort Wayne in 1939. A former president of the Lutheran Hospital medical staff, Dr. Somers was a member of the Fort Wayne (Allen County) Medical Society.

Robert H. Wiseheart, M.D.

Dr. Robert H. Wiseheart, a Lebanon specialist in ear, eye, nose and throat, died April 20 at the age of 58.

Dr. Wiseheart had practiced medicine in Lebanon since 1941 and was a 1934 graduate of the I.U. School of Medicine. He also practiced at North Salem before serving in the Air Force in World War II. Dr. Wiseheart served a year as chief of staff at Witham Hospital at Lebanon, was a member of the Lebanon Community School Board and a former president of the Boone County Medical Society. ◄

COMMERCIAL ANNOUNCEMENTS

BUY AND TRY: Wye Plantation Aberdeen-Angus frozen semen from Advanced Register P.R.I. sires officially gaining over four pounds per day or whose 365-day weights are above 1,200 pounds. (Performance tested sires always for sale.) WYE PLANTATION, Queenstown, Maryland 21658. Telephones: 301-827-7166 or 301-827-7160.

WANTED: GP or internist for VA Outpatient practice, consisting of examinations and treatment, either part-time or full-time 40 hours per week. Salary commensurate with professional qualifications and experience. If interested, please contact Personnel Division, V.A. Hospital, 1481 W. Tenth St., Indianapolis, Indiana 46202 or call 635-7401.

GENERALISTS AND PSYCHIATRISTS: In accredited progressive 2000-bed mental hospital with approved psychiatric residency training program. Ideal living in active resort community located in Michigan's serene, scenic water-wonderland. Salary $22,550-$30,464, depending on qualifications. (Salary rates effective July 1, 1969). Unparalleled retirement and fringe benefits. Contact M. Duane Sommerness, M.D., Superintendent, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

PSYCHIATRIC RESIDENCIES: We offer nothing but excellent psychiatric training in a stimulating, well organized program located in a culturally advantaged community. Approved psychiatric training. Traverse City State Hospital, Michigan Department of Mental Health. Three and five year programs. Salary, 3 year program: $10,669; $11,191; $12,131. 5 year program: $12,152; $14,031; $16,328; $21,944; $23,093. NIMH-GP stipends available. Located in Michigan's serene, scenic recreation area on Grand Traverse Bay. Contact Dr. Paul E. Kauffman, Director of Training, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

AVAILABLE: Medical suite. Established practice in professional building, 6049 E. Washington St., Indianapolis. All services furnished. Phone Modern Pharmacy, 359-5569.

FOR IMMEDIATE OCCUPANCY in the new addition to the Greenwood Professional Building. New electrically heated and cooled ultra modern doctor's office. Exterior walls are insulated. All glass is Thermopane. Building houses Greenwood Clinical Laboratory and Greenwood X-ray Laboratory. Both are Medicare approved.

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Home Lawn Mineral Springs 841
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Lilly, Eli & Company 792
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Mutual Medical Insurance, Inc. 775
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Parke, Davis & Company 816
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Sandoz Pharmaceuticals 843
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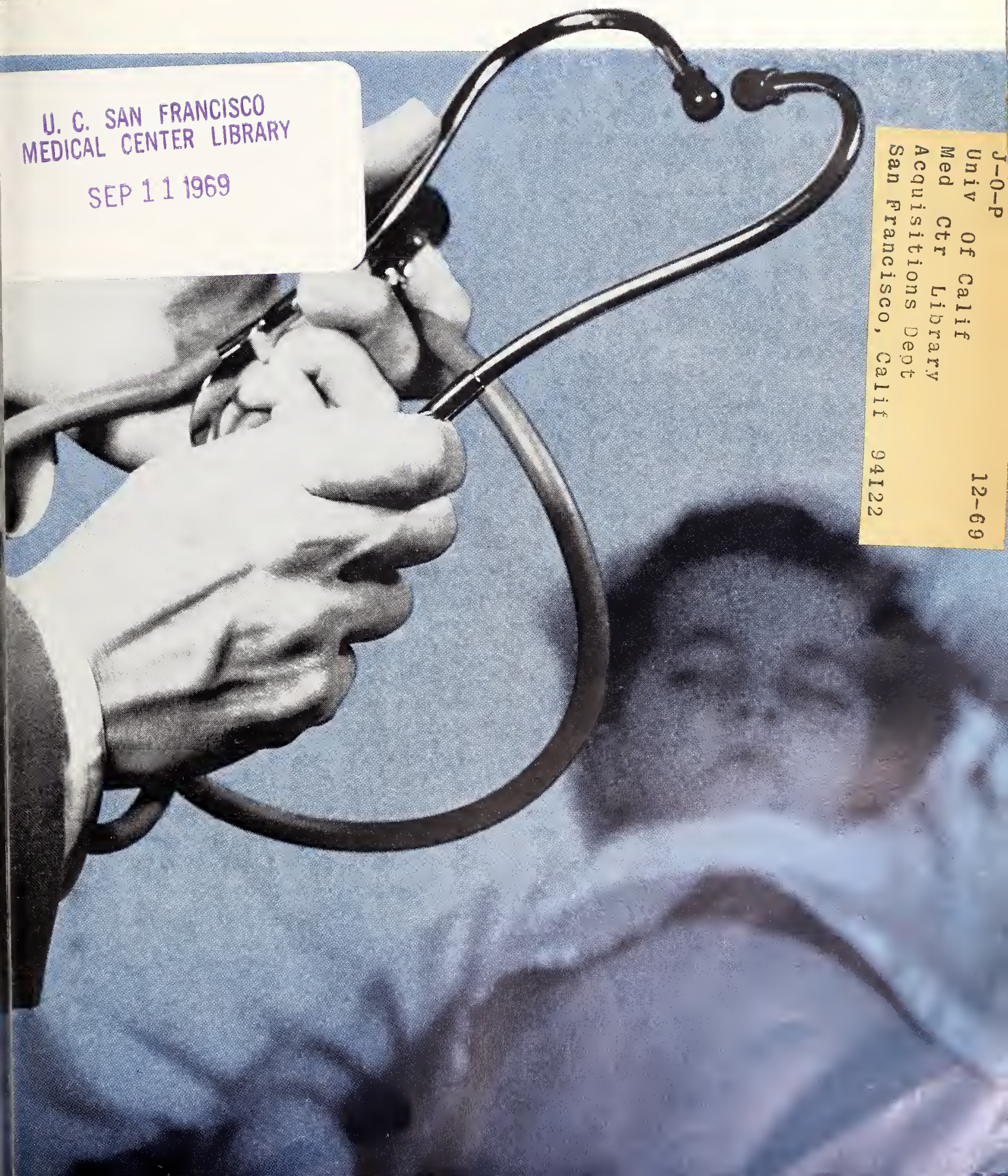
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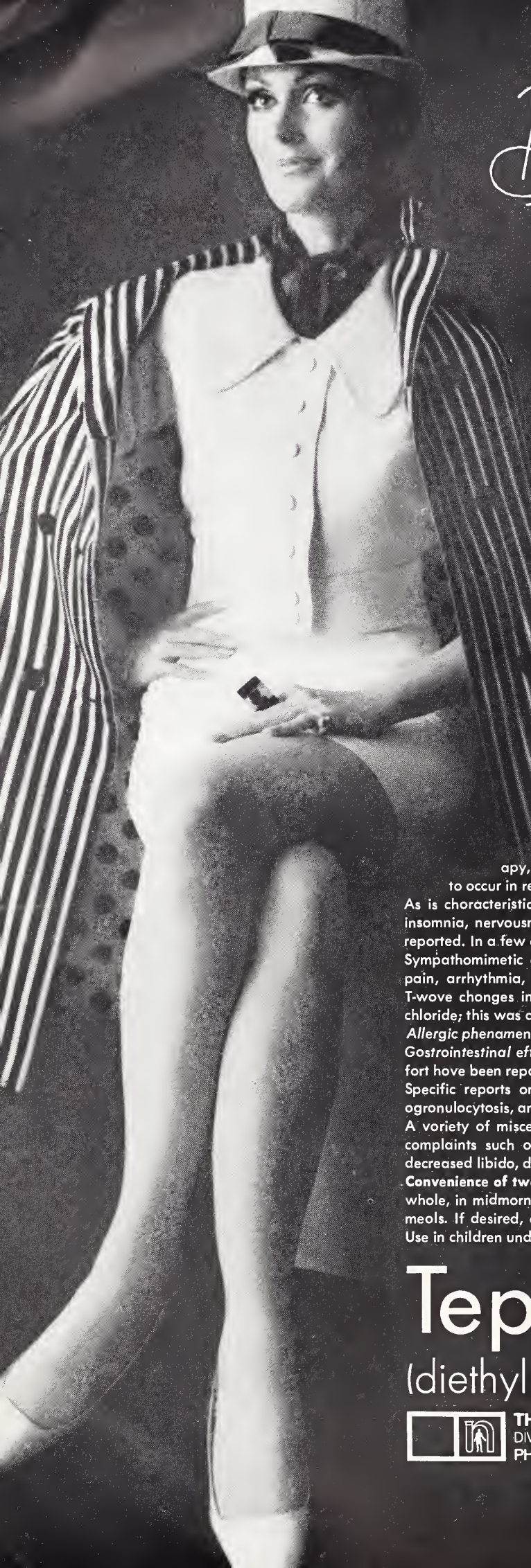
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Contents

SCIENTIFIC

Treatment of Congestive Heart Failure with Furosemide, Richard M. Nay M.D., Indianapolis 887

The Coronary Care Unit in a Small Hospital, Robert D. Robinson Jr., M.D., Bloomington 895

Principles of Therapy in Cerebral Vascular Disease, Mark L. Dyken, M.D., Indianapolis 898

Physician Manpower—"Telling It Like It Is," Kenneth E. Penrod, Indianapolis 905

Electrocardiogram of the Month: Pacemaker Electrocardiography (1), Charles Fisch, M.D., Indianapolis 910

X-Ray Conference: Sequestration of the Lung, Erich K. Lang, M.D., Shreveport, La. .. 913

EDITORIALS

Biological Research 914

Now's the Time to Utilize our Fresh Opportunities (Guest) 914

Editorial Notes 915

SPECIAL FEATURES

Medicaid in Indiana, William R. Sterrett, Administrator, State Department of Public Welfare, Indianapolis 920

Interest in ISMA Preceptor Program Continues to Grow 922

County Medical Society Officers Conference, April 12-13, 1969, Indianapolis 933

REGULAR FEATURES

What's New? 873

President's Page 875

Month in Washington 876

The Woman's Auxiliary Reports to ISMA 919

Day by Day with the FDA 921

A Banner Year for Blue Shield (One of a Series) 928

Medicine at Law 952

Abstracts, Book Reviews 960

Board of Health Report 963

News Notes 964

From The Journal 50 Years Ago 970

Annual Meeting Dates of Professional Medical and Allied Organizations 971

Future Meetings, Seminars, Courses 972

Deaths 974

BUSINESS

Board of Trustees: March 26, 1969 975

Executive Committee: March 25, 1969 983

April 26, 1969 984

May 25, 1969 986

June 28, 1969 987

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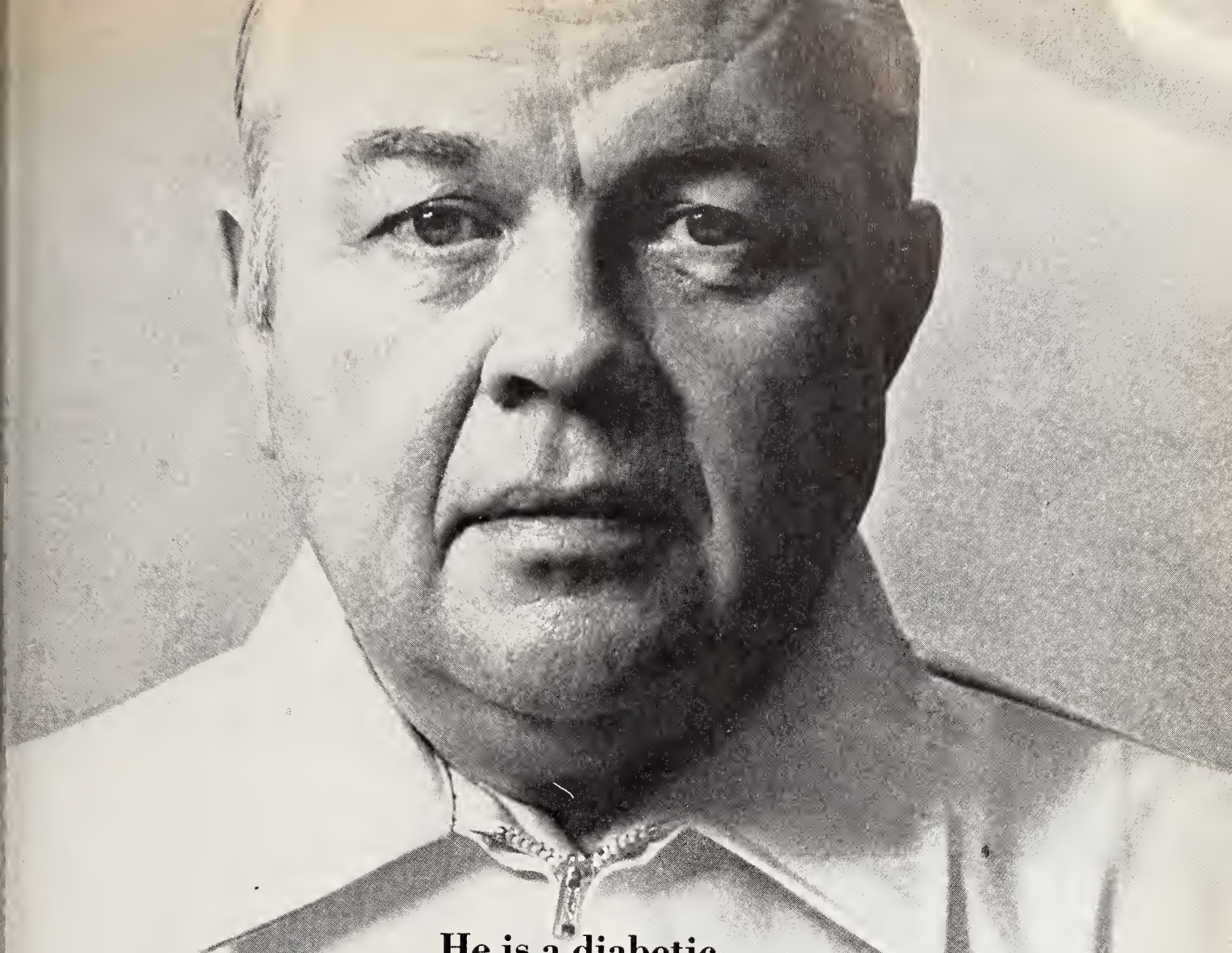
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duce an exaggerated sunburn reaction which may range from ery-
na to severe skin manifestations. In a smaller proportion, photo-
rgic reactions have been reported. Patients should avoid direct
osure to sunlight and discontinue drug at the first evidence of skin
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es should be carefully observed.

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2—Betty Dukes, Dugger	197
3—Elmer L. Wallace, New Albany	197
4—Jack E. Shields, Brownstown	197(
5—Cleon M. Schauwecker, Greencastle	197(
6—Frank Green, Rushville	196
7—John O. Butler, Indianapolis	196
8—Paul Sparks, Winchester	197(
9—Lindley Wagner, Lafayette	197
10—Charles T. Disney, Gary	196
11—James A. Harshman, Kokomo	197
12—Frederic L. Schoen, Fort Wayne	197
13—G. Beach Gattman, Elkhart	197(

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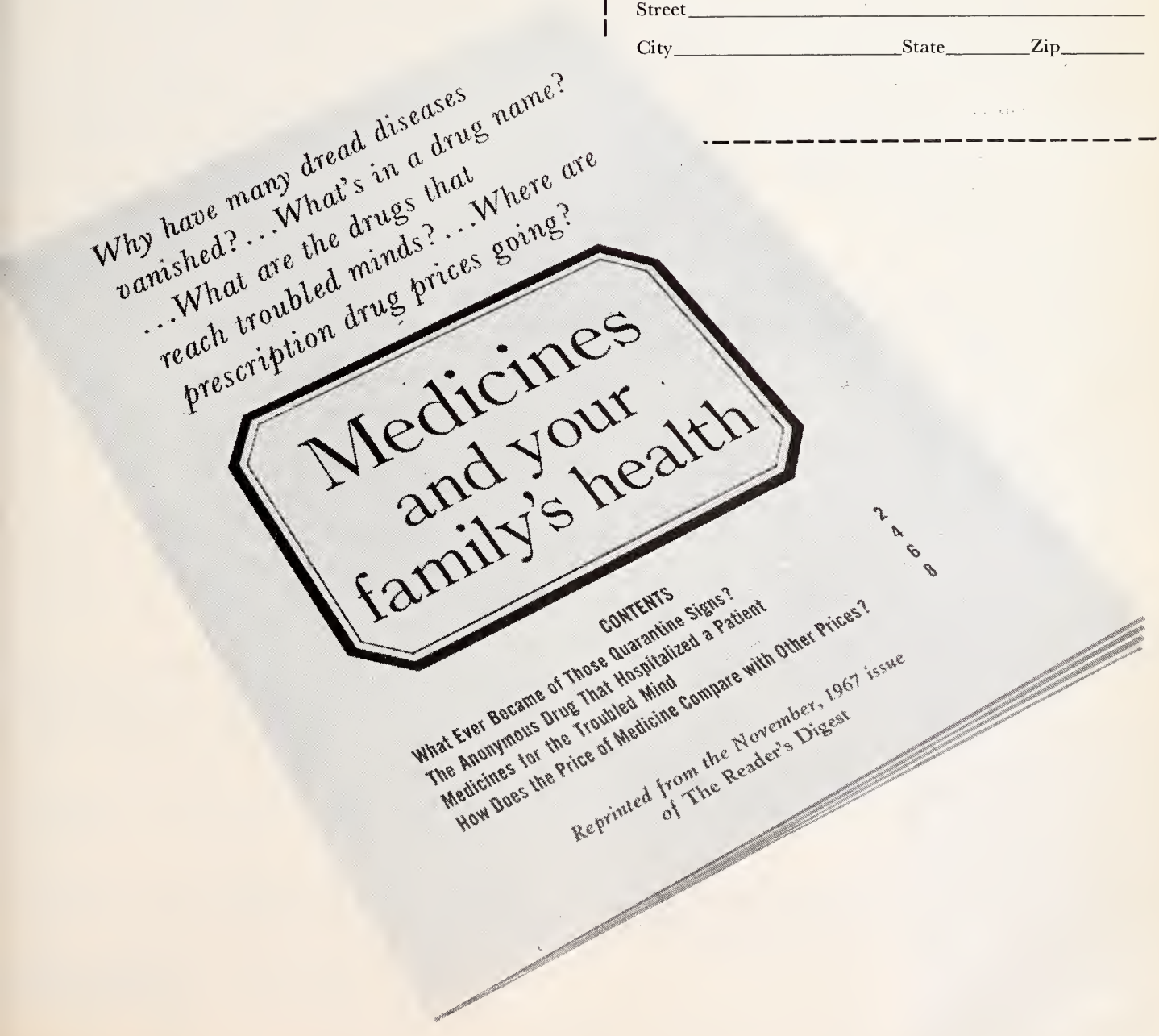
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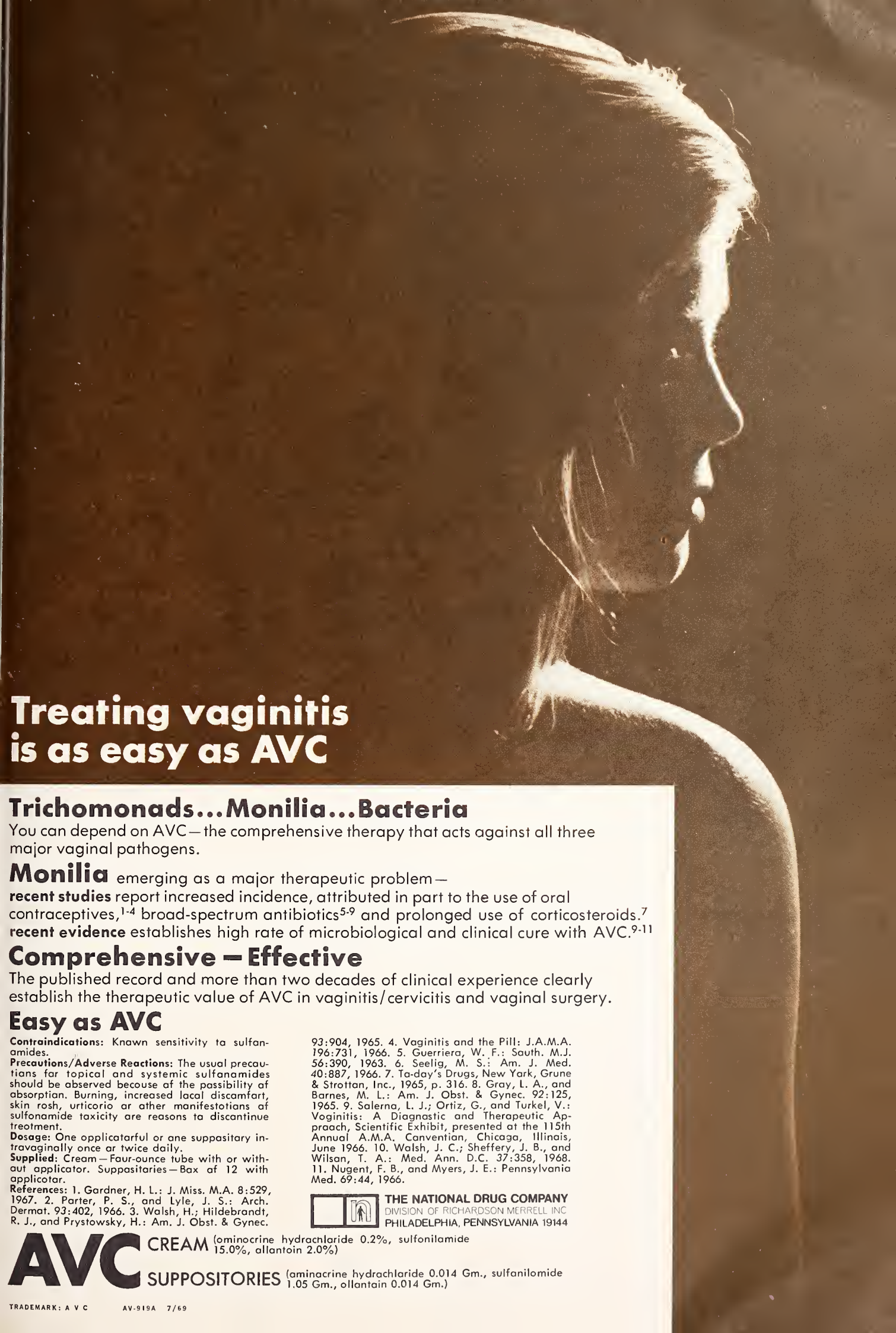
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References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Parter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriera, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. Ta-day's Drugs, New Yark, Grune & Strattan, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerna, L. J.; Ortiz, G., and Turkel, V.: Voginitis: A Diagnastic and Therapeutic Appraach, Scientific Exhibit, presented at the 115th Annual A.M.A. Canventian, Chicaga, Illinais, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilsan, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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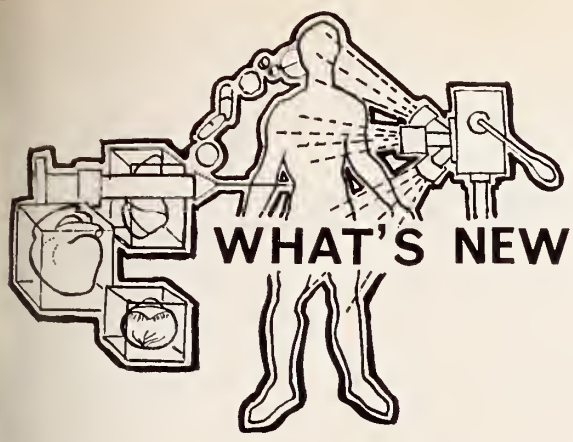
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Parke-Davis announces three new orthopedic appliances. The products are the Cervical Support Collar in four sizes; the controlled-expansion Rib Belt in five sizes and contour-designed for men and women; and the nonstretch Meek Clavicle Brace in four sizes. All three are machine washable and hot-air dryable for easy maintenance.

* * *

Masury-Columbia is offering two germicidal cleaners and one disinfectant under the trademark Yellow Jacket. All are phenol derivative concentrates. Each is designed for special cleaning and disinfecting jobs in the hospital and each is recommended for eliminating specific bacterial strains.

* * *

"The Drinking Game and How to Beat It" is a book recently released by Simon and Schuster, written by a recovered alcoholic. It discusses alcoholism as a complex disease and outlines a practical easily-understood program for permanent recovery. The price is $4.50. Professional personnel who work with alcoholics have rated the book as excellent.

* * *

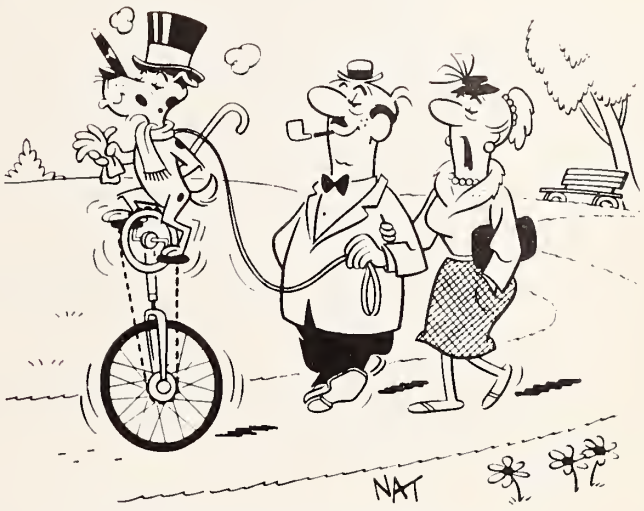
A new "doctor" book has been released. Doubleday announces publication of "Testimony of Two Men," a novel by Taylor Caldwell, which tells of a brilliant and persecuted physician in what is described as a chronicle of love, death, redemption and the rise of modern medicine against nineteenth-century opposition and ignorance. 605 pages for $6.95.

* * *

The ISA Multi-Channel Stethoscope is a portable electronic stethoscope for group teaching. Each one of six students may listen to the same sounds as the instructor by applying his acoustic stethoscope to one of six "artificial chests" on the instrument. Heart sounds are reported to be reproduced faithfully and may be amplified if necessary without distortion. International Sales Associates of Langhorne, Pennsylvania, are the makers.

* * *

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Art, Hobby Show Planned For ISMA Indianapolis Meeting

Space will be provided at the 1969 annual meeting of the Indiana State Medical Association, Oct. 13-16 at Indianapolis for a Physicians Art and Hobby Show.

Members of ISMA and ladies auxiliary interested in exhibiting pieces and requiring any information regarding this can contact any one of the following:

Dr. & Mrs. C. P. Schneider
2211 W. Franklin St.
Evansville

Dr. & Mrs. R. H. Burnikel
2709 Washington Ave.
Evansville

Dr. & Mrs. T. E. Caylor
303 S. Main St.
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51 S. Eighth Street
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ISMA Headquarters
3935 N. Meridian
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Dr. & Mrs. R. F. Green
614 W. Berry St.
Fort Wayne

Dr. & Mrs. T. T. Suzuki
Covington

Dr. & Mrs. W. L. Harlan
3700 Bellemeade
Evansville

It will be the responsibility of each physician to see that his work gets to the exhibition at the Murat Temple. Final arrangements will be taken care of by Drs. Schneider and Burnikel, co-chairmen.

The ISMA will provide suitable display facilities, but each physician and lady is responsible for transportation costs and any other such expense involved in entering his exhibit.

We solicit your exhibit and that of the ladies auxiliary, to make this the largest and best ever this year.

Application for Space in Art and Hobby Show Exhibit

Mail to:

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville 47712

Name_____

Address_____

City_____

Type and number of pieces to be displayed: Photography_____

Sculpture_____

Crafts_____

Painting_____

Other_____

Estimated amount of space required—lineal or square feet_____

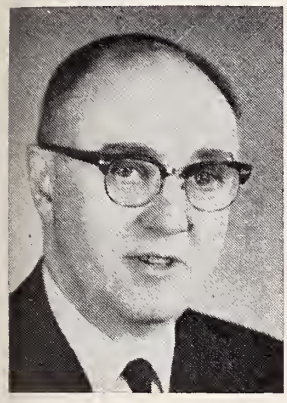
Other information_____

President's Page

General Practice—Today and Tomorrow

This issue of *The Journal* honors the General Practitioner. The wide spectrum of involvement of his field of medicine magnifies the changes and developments affecting it.

Even the name might be changed. Possible titles which have been suggested are Primary Physician or Family Physician. The newly established American Board of Family Practice signalizes the concept of a delineated field of activity. This involves proficiency in various aspects of internal medicine, pediatrics, emergency surgery, psychiatry, public health, and obstetrics-gynecology.



The physician who commits himself to this form of practice must have a calling—in truth, a *vocation*. To remain committed, he must derive sustained vocational gratification.

Incentives include recognition, rewards, desirable working conditions and family and personal satisfaction.

Recognition means that the physician who undertakes the primary obligations of health care delivery is not relegated to a secondary status in prestige. Bearing the brunt of making the crucial initial decisions, he should be equally as prestigious as the limited specialist to whom he may entrust the technical procedures of further diagnosis or therapy.

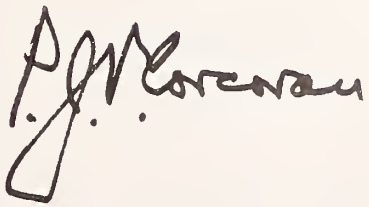
Rewards mean that payments for services are commensurate with the training and skill required, the time and effort expended, and the risk and hazards entailed. There are only so many total dollars available for health care, and these must be apportioned fairly. For this reason, the relationship of fees among all professional services should be regularly reviewed and suitably revised by representation of all those involved.

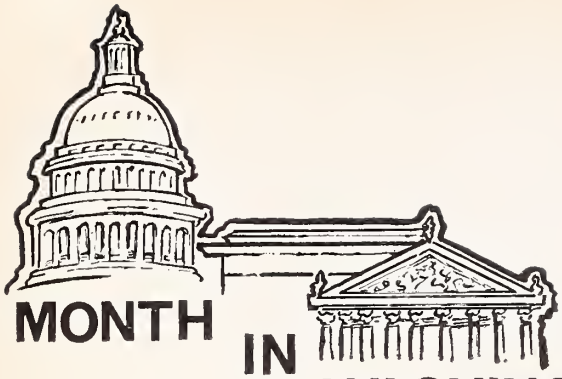
Desirable working conditions mean a work load that is not ever-increasing, compared with others. In our highly mobile society, personal relationships are decreasing; the science of medicine overshadows the art; the widening scope of our services extends more and more beyond the capabilities of a single practitioner, resulting in fragmentation and compartmentalization of care. Group or shared practices can provide predictable schedules with benefit to the patients, who can depend on available care, as well as to the physician, who can lead a more "normal" life.

The rapidly-burgeoning supportive techniques of automation, computers, communications, labor-saving equipment and ancillary health team workers can be enlisted in promoting this.

The family and personal satisfactions of a doctor are significant in determining where he settles and whether he remains there. Cultural, social and educational facilities are vitally important factors.

The initial attraction to a particular type of practice stems from many subtle determinants, some preceding medical school. Although personal emotional attitudes are fundamental, the ultimate decision depends on the many factors discussed above.





MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

WASHINGTON, D.C.—The Internal Revenue Service plans to audit the federal income tax returns of physicians and other health practitioners who have received more than $25,000 a year in medicare and medicaid payments.

PLANS FOR THE special audit were disclosed by IRS Commissioner Randolph W. Thrower at the first of a series of public hearings the Senate Finance Committee is holding in its investigation of the rising costs of the two government health care programs. He said the Department of Health, Education and Welfare had agreed to require intermediary insurance carriers to use physicians' social security numbers on reports of payments under the program in the future.

FINANCE COMMITTEE CHAIRMAN Russell B. Long (D., La.) estimated "possibly as many as 10,000" had been getting upwards of $25,000 a year under the programs. Thrower said the initial audits would be for 1967 and would be limited to those receiving more than $50,000.

LONG SAID THAT THE investigation of the committee's staff so far showed "widespread abuse, and fraud, as well as lax administration."

ROBERT M. BALL, social security administrator, reported his investigators had looked into more than 700 possible fraud cases under medicare. He said more than 300 of these cases were still in some stage of inquiry, and that 14 had been turned over to the Justice Department for prosecution.

"BUT THESE SHOULD not be taken as a reflection on the 200,000 doctors participating in medicare," Ball said. He added a bigger problem than outright fraud were "cases that don't quite become fraud."

HEW UNDERSECRETARY John G. Veneman told the committee that the Nixon Administration wants congressional authority to stop medicare payments to doctors who overcharge, use inferior supplies or engage in fraud.

"UNDER PRESENT MEDICARE LAW, there is no authority for the program to deny reimbursement to a licensed practitioner, who has demonstrated

a clear pattern of fraud, repeated overcharging in the program or the use of supplies which are inferior or harmful," Veneman said.

"WE ARE RECOMMENDING AUTHORITY . . . to discontinue future reimbursement and to put all parties on notice to this effect where, on the basis of clear evidence, a finding is made that this is justified by reason of such abuses."

COMMENTING on the hearings, Dwight L. Wilbur, M.D., president of the American Medical Association, said that the vast majority of physicians serving medicaid patients are not overcharging for their services.

"MOST PHYSICIANS," Dr. Wilbur said, "are acting honorably and with utmost restraint. Fortunately, very few M.D.'s participating in medicaid are guilty of overcharging and otherwise exploiting the program. Such exploitation by a minuscule minority was unavoidable . . . .

". . . THE MEDICAL PROFESSION is making a great effort to identify and weed out dishonest doctors who betray their oath as professional men serving the public. We have been successful in this search, but a few physicians remain who still are not identified. We shall search them out and expose them, for the good of the entire profession."

MEANTIME, HEW issued a regulation limiting the fees paid by states to physicians, dentists and other health practitioners under medicaid.

UNDER THE REGULATION, a state's medicaid payment to a physician for a service will be limited, with one exception, to the 75th percentile of the customary charge—the maximum customary fee of 75% of the physicians in the area.

IF A STATE has been paying more than the 75th percentile of the customary charge, it must not exceed the medicare level, about the 83rd percentile. A medicaid official said that only two states may have to roll back their fees, but declined to name them.

AFTER JULY 1, 1970, states may request permission to increase physicians' fees above the 75th percentile if two conditions are met:

1. The average percentage increase requested above the 75th percentile on January 1, 1969, may not exceed the percentage increase in the all-services component of the Consumer Price Index (adjusted to exclude the medical component) or in an alternate index designated by the Secretary of Health, Education and Welfare.
2. Evidence must be clear that the providers and the states have cooperatively established effective utilization review and quality control systems.

THE NEW FEE REGULATION also requires states to revise their medicaid plans to include descriptions and details of their payment structures. A state that wishes to revise its payment structure for practitioners' services or

Continued

change the payments authorized under it may not do so until the proposed changes have been approved by the Secretary of Health, Education and Welfare or his representative.

STATES THAT BEGIN their medicaid programs after July 1, 1969, must arrange their payment structures so that fees do not exceed the 75th percentile of customary charges.

HEW ESTIMATED the regulation would result in a saving of $65 million in the first year.

DESPITE A STRONG PROTEST by the American Hospital Association, HEW discontinued the overhead medicare-medicaid percentage allowance paid to hospitals, extended care facilities and other institutional providers. It was two percent for non-profit and one-and-one-half percent for proprietary institutions. The action was effective July 1, 1969.

ANOTHER NEW medicaid regulation requires states to provide periodic health screening, diagnosis, and treatment for all eligible youths under 21 years of age, effective July 1, 1969.

HEW ALSO ESTABLISHED a new classification of institution—called intermediate care facility—eligible to receive federal contributions for the care of aged, blind, or disabled recipients. This is covered in another regulation. This should reduce costs of medicaid by allowing states to relocate substantial numbers of welfare recipients who are now in skilled nursing homes in lower cost institutions, HEW said.

NEW HEW ASSISTANT SECRETARY NAMED

DR. ROGER O. EGEBERG, who has been dean of the School of Medicine, University of Southern California since 1964, was selected to be the new Assistant Secretary of Health, Education and Welfare for Health and Scientific Affairs after a five-month delay.

PRESIDENT NIXON nominated Dr. Egeberg after HEW Secretary Robert H. Finch "reluctantly and regretfully" withdrew his unannounced but widely-publicized selection of Dr. John H. Knowles, director of Massachusetts General Hospital, Boston. Finch said that "the protracted and distorted discussion" about the appointment during the five months the post had been vacant "resulted in a situation in which he [Knowles] would not be able to function effectively in this critical position."

THE NEWS MEDIA—press, radio and television—generally assigned the opposition to Dr. Knowles to conservative members of Congress, led by Senate Republican Leader Everett M. Dirksen, and to the AMA.

THROUGHOUT the public controversy before the appointment, the AMA confined its comment to a short statement that it had suggested several names to Finch for the post and that the association "favored the appointment of someone who would represent the broadest scope of medicine and would not be too closely oriented to any one segment of medicine or the health field." Knowles was not one of the physicians on the AMA list.

A FEW DAYS after the nomination of Dr. Egeberg, Dr. Dwight L. Wilbur, the AMA President, said:

"DURING THE LAST FIVE MONTHS the American Medical Association has been identified repeatedly as a force opposing appointment of Dr. John H. Knowles as Assistant HEW Secretary for Health and Scientific Affairs.

"WE HELD OUR silence during the last months of nationwide publicity because we agreed with Secretary Finch to make our suggestions to him and then say no more. We did that. The Knowles protagonists obviously did just the opposite . . . .

"IN A TRUE SENSE, we never opposed Dr. Knowles. But we did not support him because we had alternative recommendations."

THOSE RECOMMENDED by AMA for the position, Dr. Wilbur said, included:

—DR. W. CLARKE WESCOE, former Chancellor of the University of Kansas, "who withdrew soon after because of personal reasons."

—DR. RICHARD S. WILBUR, Palo Alto Clinic, chairman of the Council of the California Medical Association, and former chairman of the Board of California Blue Shield, "who happens to be my nephew, a fact which complicated the situation, but who AMA felt was a well-qualified man for this position."

—DR. JOHN R. HOGNESS, Dean of the University of Washington School of Medicine, "who serves in the AMA House of Delegates, at a high level in the Association of American Medical Colleges, and who has many other distinguished achievements."

THE AMA COMMENDED the selection of Dr. Egeberg. In a telegram to Finch, Dr. Wilbur said:

"WE LOOK FORWARD to a productive relationship with you and Dr. Egeberg in advancing the health care system for the benefit of all the American people. There are many complex factors involved that will call for the wholehearted dedication and contribution of all in the medical profession and in government.

"WE BELIEVE Dr. Egeberg will be able to bring about the necessary close coordination between government and private sectors in the health care system," Dr. Wilbur said in a supplementary statement. "This is vital to constantly advance and expand the ability to provide quality health care for all Americans."

DR. EGEBERG, 65, is a large, bluff man of Norwegian stock who demonstrated a sense of humor at his first news conference. He is a member of the AMA and a diplomate of the American Board of Internal Medicine. Generally considered a moderate liberal on health matters, he

Continued on page 885.



Clues to PVD

The heavy smoker with vasospasm

He may be comparatively young or approaching middle age. Typically, he is a heavy cigarette smoker—a pack or more a day for a number of years. Whether smoking is a causative or an important exacerbating factor in peripheral vascular disease is still under discussion. But the vasoconstrictive effects of nicotine are firmly supported by a substantial body of laboratory and clinical evidence, and the close association is now generally accepted.

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Before prescribing Roniacol Timespan (nicotinyl alcohol tartrate), please consult complete product information, a summary of which follows.

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CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other CN depressants. As with all CNS-acting drugs, cau tion patients against hazardous occupations re quiring complete mental alertness (*e.g.*, operatin machinery, driving). Though physical and psy chological dependence have rarely been reporte on recommended doses, use caution in ad ministering Librium (chlordiazepoxide hydro chloride) to known addiction-prone individual or those who might increase dosage; withdrawa symptoms (including convulsions), followin discontinuation of the drug and similar to thos seen with barbiturates, have been reported. Us of any drug in pregnancy, lactation, or in wome of childbearing age requires that its potentia benefits be weighed against its possible hazards As with all anticholinergic drugs, an inhibitin effect on lactation may occur.

PRECAUTIONS: In elderly and debilitated limit dosage to smallest effective amount to pre clude development of ataxia, oversedation o confusion (not more than two capsules per da initially; increase gradually as needed and toler

or here.



ated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

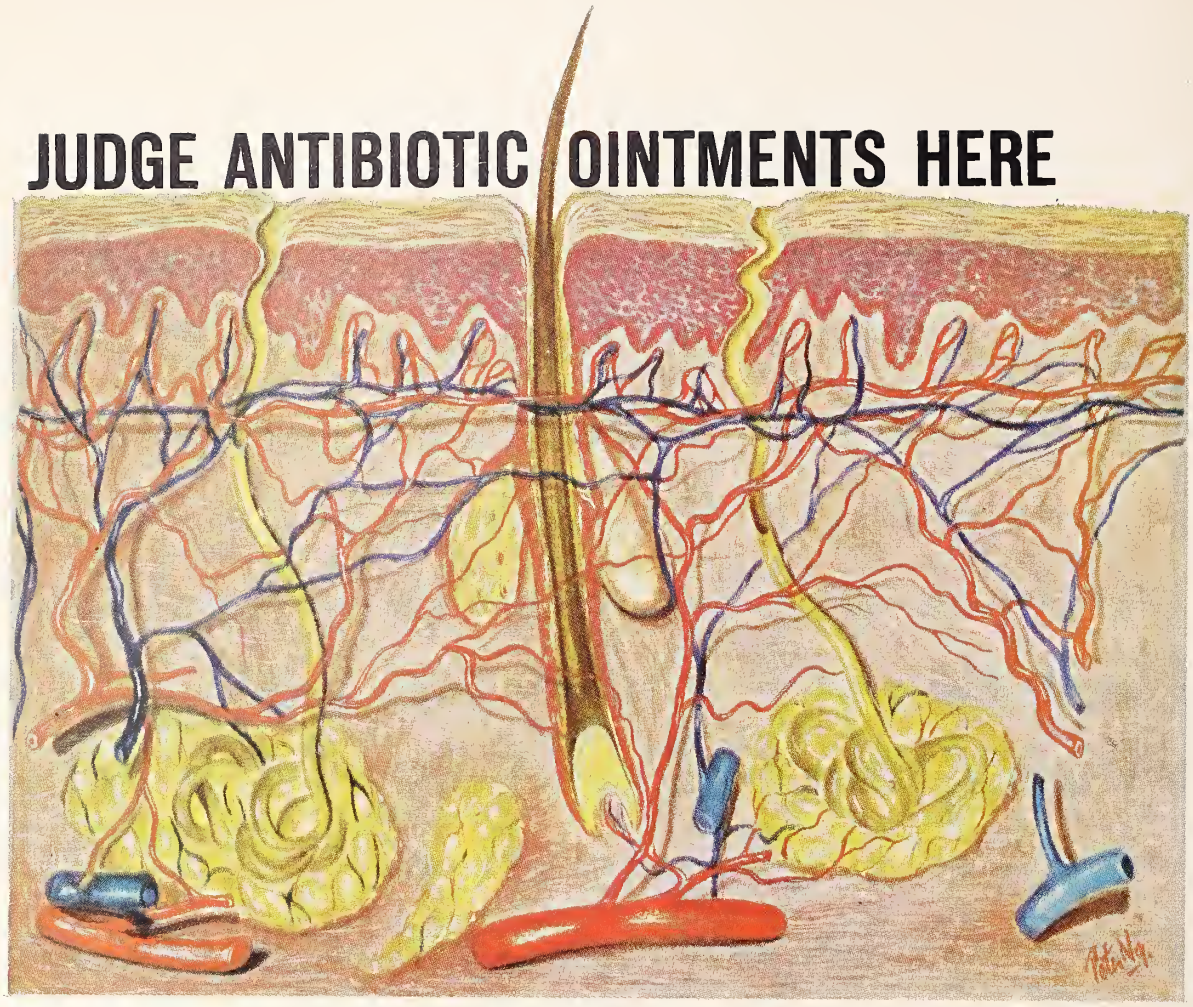
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Continued

served on several advisory commissions during the Kennedy and Johnson Administrations and on the state level in California. One of his major interests has been health care of the poor and he arranged for the USC medical school to be the medical consultant for the neighborhood health center in the Watts district of Los Angeles.

AT HIS FIRST news conference in HEW, he classified delivery of health care as almost the department's number one problem. He said medicare now is "rather well established" in solving a problem. But medicaid, he said, "has run afoul of a number of things, and I don't know that one can blame any one person or any group for this."

A MEMBER OF THE army medical corps in World War II, he was personal physician and aide-de-camp to General of the Army Douglas MacArthur, 1944-45. ◄

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION
Supervised by THE COUNCIL
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A new safe and effective diuretic which is useful in CHF has few side effects and demonstrates good patient acceptance.

Treatment of Congestive Heart Failure with Furosemide*

RICHARD M. NAY, M.D.**
Indianapolis

SINCE their introduction in 1957, the benzothiadiazine diuretics have been of clinical value in the ambulatory patient with congestive heart failure. These drugs are often effective when used alone, or in combination with an aldosterone antagonist or an organomercurial for "resistant" cases.

Recently, however, there has been increasing interest in a new diuretic, furosemide, (4-chloro-N-furfuryl-5-sulfamoylanthranilic acid). This compound inhibits filtrate reabsorption in the ascending limb of the loop of Henle, as well as in the proximal and distal segments of the renal tubule;[1-3] it has an unusually prompt onset and short duration of action[4] and a wide effective dose range. Clinically, it is reported to be highly effective.

Hutcheon et al.[5] compared the effects of furosemide with those of polythiazide in 20 ambulatory patients with congestive heart failure. In terms of weight loss at maximal doses, furosemide has a wide range of effectiveness, as compared with polythiazide. Furosemide showed a clearly defined, dose-response relationship, whereas polythiazide did not.

Kleinfelder[6] reported his experience with furosemide in 36 patients with edema of cardiac origin. Edema was completely eliminated in 34 patients. Doses as low as 50 mg./day often induced a urinary output of from 1.5 to 3.8 liters.

Peltola[7] used furosemide in 90 patients with cardiac edema, 22 of whom had become refractory to other diuretics. A good diuretic response, with complete clearance of the edema, was observed in 87 patients (20 of the 22 refractory cases). The daily doses ranged from 25 to 120 mg. More recent studies have shown the value of furosemide in pulmonary edema[8,9] and documented its effectiveness in congestive heart failure.[9-11] Atkins[12] reported furosemide a significant advance in the routine office management of mild congestive heart failure as well as in more severe cases refractory to thiazides. Soffe[13] found furosemide superior to thiazides for home and office treatment of cardiac edema.

The present report describes our experience with furosemide administered orally, either as the sole diuretic or in combination with furosemide injection, or an organomercurial intramuscularly.

Materials and Methods

Twenty-two outpatients were selected from private practice for study. The history of each patient was carefully reviewed, a complete physical examination was given, and the indicated x-ray, electrocardiographic and laboratory studies were performed prior to inclusion in the study group.

Congestive heart failure was present in 21 patients and ascites secondary to cirrhosis in one patient. Arteriosclerotic heart disease was noted in 15 patients, old myocardial infarction in eight, hypertension in six and pulmonary emphysema in three patients. One patient had aortic stenosis, another had mitral insufficiency, and

*Supplied as Lasix® by Hoechst Pharmaceutical Co., Cincinnati, Ohio.

** Associate Professor of Clinical Medicine, Indiana University Medical Center, Indianapolis 46202.

there were single cases of atrial fibrillation, paroxysmal tachycardia and angina pectoris.

Fourteen patients (Group 1) were given furosemide only by the oral route. Therapy was continued for periods of 30 to 266 days.

Eight other patients (Group 2) also received furosemide orally, but this was supplemented at times by furosemide or an organomercurial given intramuscularly. Four patients were given furosemide I. M. and four received organomercurials intramuscularly.

Classification of the overall efficacy of the diuretic involved consideration of its effects on body weight, peripheral edema, pulmonary congestion, dyspnea, etc., as well as the subjective response of the patient. Furosemide was judged to be very effective when dry weight was achieved and maintained. It was moderately effective if some evidence of fluid retention persisted, and ineffective if there was little or no diuretic activity. The daily dose ranged from 40 to 120 mg. The initial dose was continued without change in 12 patients, while in five others it was reduced, and in five it was increased in accordance with the response.

Results

In the group who were treated only with oral furosemide, therapy was considered to be very effective in nine patients (64%), moderately effective in four (29%) and ineffective in one. The only patient who failed to show an adequate response, Case No. 13, died of a myocardial infarction during the course of therapy. Death was not attributed to furosemide. The laboratory and clinical data on the patients in Group 1 are summarized in Table 1.

The average weight changes in 12 patients was 5 lb. (range 7 to 17 lb.). Ten patients lost an average of 7.8 lb., while two others gained weight. One of these, Case No. 8, was a patient with cirrhosis who resumed drinking during therapy. Improved appetite

GROUP I

DESCRIPTION OF PATIENTS AND THERAPY

PATIENT	AGE	SEX	DIAGNOSIS	PREVIOUS THERAPY	FUROSEMIDE DOSE (mg.)	FUROSEMIDE DURATION (days)
1	--	F	CHF, ASHD,* old myocardial infarct	thiazides, mercurials, low salt diet	40	69
2	68	M	CHF, ASHD	thiazides, mercurials	80	33
3	64	M	CHF, ASHD, hypertension	thiazides, mercurials	40 40-80**	157 69
4	68	F	CHF, ASHD, old myocardial infarct	thiazides	40	187
5	74	M	CHF, ASHD, hypertension, atrial fibrillation	thiazides, mercurials	80	188
6	--	F	CHF, ASHD, atrial fibrillation	thiazides, mercurials	80 40	3 245
7	71	F	CHF, ASHD	thiazides, mercurials	40	117
8	52	M	cirrhosis, ascites	thiazides, mercurials	80	119
9	64	F	CHF, hypertension	thiazides, mercurials, low salt diet	120 40-80** 40	3 18 245
10	70	M	CHF, ASHD, emphysema hypertension	thiazides, mercurials, low salt diet	40	158
11	78	M	CHF, ASHD, old myocardial infarct	thiazides, mercurials, low salt diet	80 40	7 138
12	72	M	CHF, old myocardial infarct	thiazides, mercurials	40 80	72 72
13	57	F	CHF, ASHD, old myocardial infarct, mitral insufficiency	thiazides, mercurials	80	30
14	54	M	CHF, ASHD, old myocardial infarct, paroxysmal tachycardia	thiazides, mercurials, low salt diet	80 40	28 151

*CHF - congestive heart failure, ASHD - arteriosclerotic heart disease.
**40-80 mg. doses were taken on alternate days.

GROUP II

DESCRIPTION OF PATIENTS AND THERAPY

PATIENT	AGE	SEX	DIAGNOSIS	PREVIOUS THERAPY	ORAL FUROSEMIDE DOSE (mg.)	ORAL FUROSEMIDE DURATION (days)	PARENTERAL DIURETIC
15	71	M	CHF, old myocardial infarct, angina	thiazides, mercurials	80	161	1.5 ml. F* on first day of study
16	52	M	CHF, ASHD, old myocardial infarct	thiazides, mercurials	80	212	2 ml. F on day 180 and again on day 212
17	68	M	CHF, aortic stenosis	None	40 80	14 81	1.5 ml. F on first day of study
18	62	M	CHF, hypertension	thiazides, mercurials	40 120	44 56	1.5 ml. F on first day, with 2 ml. doses on three subsequent occasions
19	42	M	CHF, cyanotic heart disease	thiazides	80 120	32 185	mercurial given once by another physician
20	58	F	CHF, ASHD, emphysema	thiazides, mercurials	80	97	mercurial given once
21	76	F	CHF, ASHD, hypertensive heart disease	thiazides, mercurials	40 120	82 76	a mercurial was used twice a week during the early part of the study
22	72	M	CHF, ASHD, emphysema	mercurials	80 80**	71 90	a mercurial was used every four to five days during mid-course

*F - furosemide
**Three days each week.

rather than fluid retention appeared to account for a moderate weight gain in Case No. 12.

Furosemide had no statistically significant effect on blood urea nitrogen. Eight patients had persistently elevated BUN, but the highest reading was only 27.9 mg./100 ml. Likewise, there was no significant effect on serum potassium. The lowest value recorded during therapy was 3.8 mEq./L. and at the conclusion of this study the lowest value observed in any patient was 4.2 mEq./L. Although serum uric acid increased in eight patients, the increase averaged only 1.7 mg./100 ml., and the average value after treatment was lower than it was before treatment. There were no symptoms of gout.

The effectiveness of orally administered furosemide is illustrated by the response of Case No. 6.

Furosemide was started on December 18, 1965 at a dose of 80 mg. daily. Although this patient had previously been treated with chlorothiazide and mercaptomerin, there was marked diuresis in response to the initial dose of furosemide. She lost seven pounds and felt much better. After three days the initial dose was reduced to 40 mg./day. She continued to improve, and on February 22, 1966 she had no dyspnea and reported feeling better than she had during all of 1965. When last seen on September 26, 1966 she had no breathing problems, her weight was further reduced but she reported that her appetite had not been very good. Furosemide was obviously very effective in this case (Figure 1).

Of particular interest also is Case No. 9 shown in Group 1 and Table 1. This 64-year-old female suffering from cardiac edema was started for three days on three tablets (120 mg.) of Lasix. Because of the good diuresis, edema was reduced to an extent that allowed a reduction of the dose to one to two tablets for 18 more days. Thereafter, the patient was at dry weight and was maintained with one tablet (40 mg.) per day for 245 consecutive days.

TABLE I

SUMMARY OF LABORATORY AND CLINICAL OBSERVATIONS

PATIENT	PERIPHERAL EDEMA Pre-	Post-Rx	BODY WEIGHT Pre-	Post-Rx	BLOOD UREA NITROGEN* Pre-	High	Post-Rx	SERUM POTASSIUM** Pre-	Low	Post-Rx	SERUM URIC ACID* Pre-	High	Post-Rx
1	1+	0	129	122	11.9	11.9	11.9	4.9	4.4	4.4	4.1	4.7	4.7
2	1+	0	176	172	12.2	12.2	9.7	5.0	5.0	5.1	6.2	6.2	5.6
3	0	0	---	---	16.2	19.9	19.9	4.8	4.0	4.9	9.2	9.2	4.8
4	0	0	114	108	11.0	12.9	12.9	4.8	4.2	4.2	6.4	6.4	3.6
5	0	0	190	176	19.9	24.0	18.0	3.9	3.8	4.4	7.2	7.2	4.5
6	1+	0	157	140	19.0	19.0	10.7	4.8	4.4	4.4	2.8	3.6	2.8
7	0	0	---	---	12.8	23.8	10.3	5.0	4.3	4.3	6.4	7.5	3.7
8	0	0	167	174	11.9	13.0	13.0	4.0	4.0	4.2	3.6	7.5	7.5
9	1+	0	125	118	15.0	21.0	12.0	5.0	4.4	5.5	4.2	6.2	4.2
10	0	0	169	162	21.0	22.6	22.6	4.1	4.1	4.9	6.5	7.4	3.9
11	0	0	125	123	20.0	27.9	27.9	6.2	5.5	5.6	6.5	6.5	4.4
12	0	0	126	130	16.0	21.5	21.5	4.0	4.0	4.6	4.7	6.9	6.9
13	0	0	139	138	11.9	17.0	17.0	---	---	---	4.3	6.7	6.7
14	0	0	175	162	14.9	17.2	17.2	5.1	3.8	5.2	5.6	5.6	2.8
Averages			149	144	15.3	18.9	16.0	4.7	4.3	4.8	5.6	6.5	4.7

*mg./100 ml
**mEq./L.

In the group of patients who received furosemide orally occasionally supplemented by parenterally administered furosemide or a mercurial, therapy was considered to be very effective in six patients (75%) and moderately effective in two others. None of these patients failed to show an adequate response. The clinical and laboratory data concerning the patients in this group are summarized in Table II.

All but one patient in this group, Case No. 15, lost weight, the average loss amounting to 10 lbs.

There was no statistically significant effect on blood urea nitrogen, serum potassium, or serum uric acid.

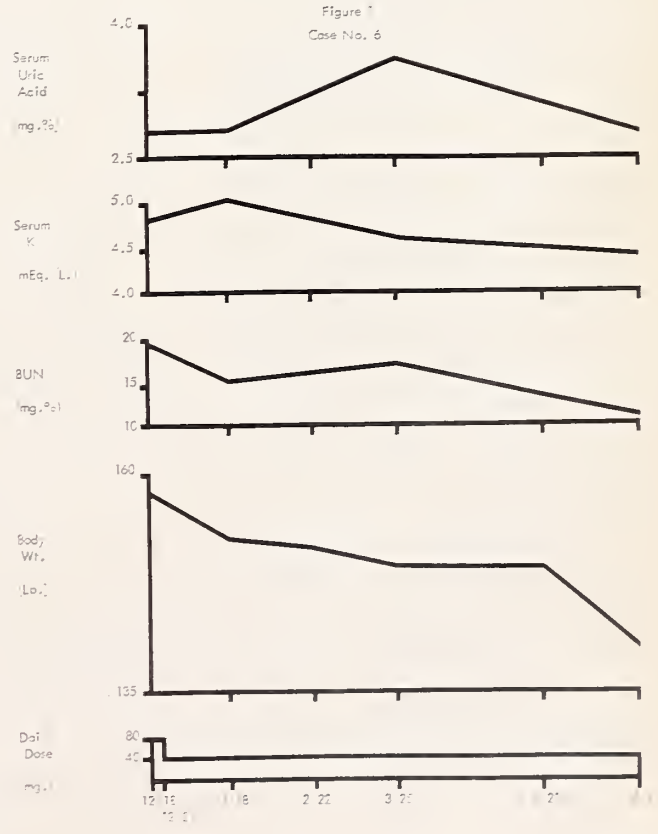


FIGURE 1

TABLE II

SUMMARY OF LABORATORY AND CLINICAL OBSERVATIONS

PATIENT	PERIPHERAL EDEMA Pre-	Post-Rx	BODY WEIGHT Pre-	Post-Rx	BLOOD UREA NITROGEN* Pre-	High	Post-Rx	SERUM POTASSIUM** Pre-	Low	Post-Rx	SERUM URIC ACID* Pre-	High	Post-Rx
15	0	0	162	163	14.9	21.9	21.9	4.0	4.0	4.6	6.7	9.4	5.4
16	0	0	239	222	11.0	18.2	18.2	4.4	4.2	4.5	5.3	5.3	4.9
17	0	0	172	165	12.2	17.0	16.7	5.3	4.7	4.7	4.2	4.6	3.9
18	0	0	172	167	22.6	27.4	27.4	5.0	4.5	5.6	3.2	4.4	4.4
19	2+	0-1+	137	129	14.9	26.0	26.0	4.6	4.6	4.7	5.0	7.8	7.8
20	0	0	105	103	8.0	12.2	9.5	4.9	4.9	5.3	1.4	5.9	4.4
21	0	0	140	131	17.4	17.4	14.4	4.9	4.9	5.0	4.5	5.9	5.9
22	3+	0	174	145	30.0	30.0	19.1	4.7	4.7	5.3	4.5	4.5	4.0
Averages			163	153	16.4	21.3	19.2	4.7	4.6	5.0	4.4	6.0	5.1

*mg./100 ml.
**mEq./L.

Blood urea nitrogen was increased in six patients but the highest level recorded was 27.4 mg./100 ml. and the average increase was only 4.9 mg./100 ml. greater than the pre-treatment average. The lowest serum potassium level recorded was 4.0 mEq./L., and on the average there was only 0.1 mEq./L. decrease below the pre-treatment level. The lowest serum potassium level recorded was 4.0 mEq./L., and on the average there was only 0.1 mEq./L. decrease below the pre-treatment level. Serum uric acid concentrations were increased in six patients. The average increase was 2.2 mg./100 ml., with the greatest increase being 4.5 mg./100 ml. Although values as high as 9.4 mg./100 ml. were observed, there were no symptoms of gout.

The response of patients receiving furosemide orally and parenterally may be illustrated by Case No. 18. This 62-year-old man was first treated for congestive heart failure in August, 1963. Hypertension had been adequately controlled by thiazide diuretics. In May, 1964, he spent two weeks in the hospital as a consequence of a severe, acute episode of pulmonary edema. In spite of continuing therapy with mercurials and thiazides, severe prolonged dyspnea recurred. Furosemide was started on June 24 with a single 2 ml. (40 mg.) dose intramuscularly. In addition, the drug was given orally at a dose of 40 mg./day. On July 19 he reported that he still felt rather weak, but he did not have any breathing problems. He was again given 2 ml. of furosemide intramuscularly, and the oral dose was continued without change. On August 4 the parenteral dose was repeated, and on August 8 the oral dose was increased to 120 mg./day. Gradual improvement followed. He became increasingly active, and when last seen his heart sounds were normal, his lungs were clear and he appeared to be much improved. Furosemide was considered to have been very effective in this patient (Figure 2).

Marked symptomatic beneficial effects were reported. While it is difficult to evaluate such reports, almost all of these patients "felt better." There was less fatigue with increased activity, greater strength, better appetite, less angina and a greatly increased feeling of well-being.

Except for slight nausea in two patients, there were no side effects. Complete blood counts, urinalyses and occasional liver function tests showed no abnormalities attributable to therapy.

Discussion

Furosemide is an effective diuretic. All of the patients in this series had been under treatment with various thiazides and/or mercurials and diuretics immediately prior to the use of furosemide. There was no diuretic-free interval. Thus, the pre-treatment findings reflect the therapeutic effects of thiazides and/o mercurials which were used. Peri pheral edema, ranging from one t three, was still present in six patients It was cleared completely in five an reduced from 2 to 0-1 in one patien with furosemide. Dry weight had no been achieved in 14 patients whe therapy with furosemide was started Furosemide was very effective (dr weight was achieved and maintained in all 14. Against the "background of prior diuretic therapy, the averag weight loss of 5 to 10 lb. (Table and Table II, respectively) become even more significant clinically. Thi lends clinical support to the do studies by Hook and Williamson[14] i which they showed greater diuresi with furosemide when given durin a maximally induced thiazid diuresis.

It is common knowledge that pa tient acceptance can be a significan factor in determining the degree o therapeutic success obtainable with a given drug. Our results indicate that in addition to being highly effective furosemide showed a high degree o patient acceptance. Symptomatic im provement was pronounced and fre quent. Activity increased, appetite improved, angina was reduced and the increased feeling of well-being, evident in many cases, almost bordered on euphoria in some. In this connection it should also be noted that the only side effect was slight nausea in two patients.

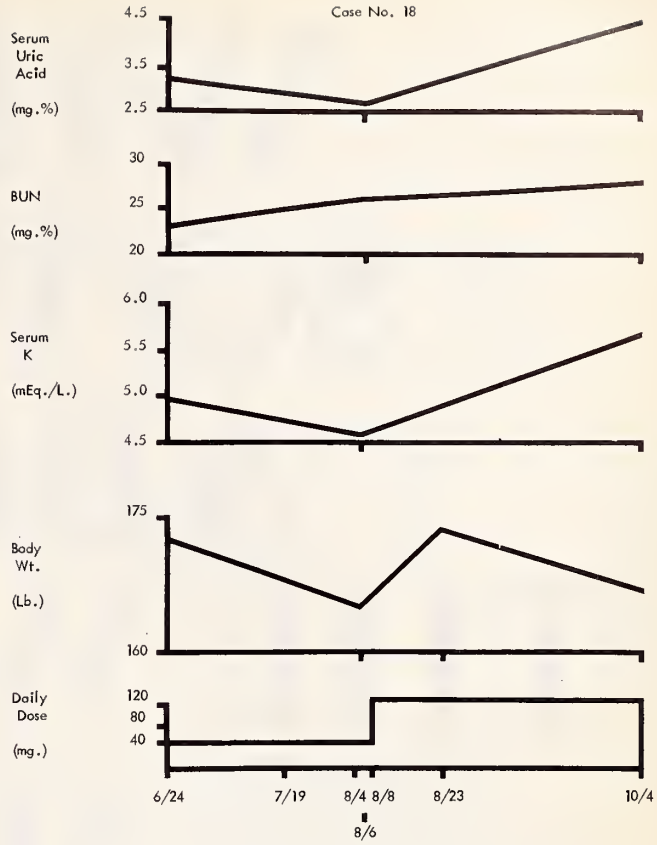
Summary

Twenty-two outpatients, 14 men and eight women, were selected from private practice to study the effects of furosemide orally and intramuscularly in congestive heart failure. Fourteen patients were given the drug only by the oral route in a daily dose ranging from 40 to 120 mg. In a second group of eight patients, four received furosemide and four others received an organomercurial intramuscularly at some time during the course of oral furosemide therapy. In this group the oral dose of furose-

ıide also ranged from 40 to 120 ıg./day. Therapy was continued for ›eriods of 30 to 266 days.

There was an average weight loss ›f five lb. in patients on oral furose- ıide alone, and 10 lb. in those on the ›ral-parenteral regimens. Peripheral ›dema was cleared completely or sub- tantially reduced in all patients in vhom it had been present prior to his study. There was no clinically ignificant influence on blood urea ıitrogen, serum potassium or serum ıric acid on either oral or oral- ›arenteral therapy. Symptomatic im- ›rovement was evident in almost all ›atients. Slight nausea was reported by two patients. There was no clinical or laboratory evidence of toxicity.

Figure 2
Case No. 18



Conclusion

It is our conclusion that furosemide is a safe and effective diuretic agent which can be particularly useful in the treatment of mild congestive heart failure. Dosage flexibility, prompt onset and brief duration allow outstanding control of diuresis and convenience in the patient's personal routine.

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Meprobamate: Carefully supervise dose and amounts prescribed. Consider possible dependence or habituation (reported occasionally after excessive use), particularly in severe psychoneurotics, alcoholics, ex-addicts. Withdraw gradually (one or two weeks) after excessive dosage for weeks or months to avoid recurrence of pre-existing symptoms (e.g., anxiety, anorexia, insomnia) or withdrawal reactions (e.g., vomiting, ataxia, tremors, muscle twitching; rarely, epileptiform seizures, more likely in those with CNS damage or latent convulsive disorders). If drowsiness or visual disturbance occurs, reduce dose and advise against activity requiring alertness (driving, machinery operation). Effects of excess alcohol may be increased. Grand mal seizures possible in persons with both petit and grand mal. Prescribe cautiously in small amounts to patients with suicidal tendencies. Prescribe with caution to patients with known sensitivity to compounds of similar chemical structure, e.g., carisoprodol.

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Meprobamate: Drowsiness, sometimes with ataxia, usually controlled by decreasing dosage, occasionally with aid of central stimulants (e.g., amphetamine). Rarely, allergic or idiosyncratic reactions (usually after one to four doses); in mild form: itchy, urticarial or erythematous, maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever, transient leukopenia, and one fatal bullous dermatitis (after meprobamate and prednisolone) reported. More severe, very rare hypersensitivity: fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (one fatal), anuria, anaphylaxis, stomatitis and proctitis. Treat symptomatically (e.g., epinephrine, antihistamines, possibly hydrocortisone); stop and do not restart the drug. Isolated agranulocytosis, thrombocytopenic purpura, one fatal aplastic anemia reported, but only in presence of known toxic drugs, porphyric symptoms reported but relationship not established. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation reported by one observer. Fixed drug eruption with meprobamate and cross reaction to carisoprodol reported.

Suicidal attempts may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse, and death. Excessive dosage has led rapidly to sleep, then reduction of vital signs to basal levels. Empty stomach, and if respiration becomes very shallow and slow, cautiously give CNS stimulants (e.g., caffeine, pentylenetetrazol, amphetamine); also pressor amines if indicated.

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(1928A01J)

Two years experience with a coronary care unit in a community hospital without a house staff demonstrates improvement in the hospital mortality rate over that achieved previously under conventional hospital care.

The Coronary Care Unit In A Small Hospital

ROBERT D. ROBINSON JR., M.D.*
Bloomington

THE concept of intensive, electrical, nursing and physician surveillance of patients in coronary care units (CCU) during the high risk period immediately following a myocardial infarction has been well described and should need no further validation.[1-5] The bulk of such studies are still reported from facilities staffed by physician personnel on a 24-hour basis and it is only recently that experience from community hospitals without house staff is beginning to appear.[6] At the present time, many hospitals throughout the state of Indiana are developing coronary care units and it is hoped that the experience of the Bloomington Hospital might be of some value to these institutions in their planning.

This communication will review our experience during the first two years of operation of the John R. Figg Cardiac Care Unit in Bloomington, Indiana.

The Bloomington Hospital is a non-profit institution supplying the bulk of medical and health needs for an approximate 92,500 service area population in Monroe and neighboring counties. It has a medical staff of 64, of which 33 are members of the medical section. There is no house staff.

The John R. Figg Cardiac Care Unit, financed by a generous donation, was opened on January 20, 1967. Four private rooms are equipped with electrical monitoring equipment with relay to slave oscilloscopes at a central nursing desk. Standard cardioversion equipment is kept constantly in the unit. The original unit nursing director participated in a six-weeks intensive training course in coronary care nursing at the Cornell Medical Center, New York City, and she and three other nurses have subsequently been sent for shorter training courses at established coronary care units. Three nurses with previous coronary care unit experience became available and in addition alert, aggressive and interested nurses have been identified from the general nursing service and have received on-the-job training in our own unit. A continuing training program has been instituted for the nurses, LPN's and backup personnel as well as for all supervisory personnel.

The CCU is supervised in a general way by a committee consisting of all interested physicians and chaired by an appointee of the chief of staff. The Coronary Care Committee makes general policy decisions and suggests "routine" coronary care, but no attempt has been made to supervise individual patient care. Admission to the unit is by bed availability, and transfer out when necessary to make room for new admissions, is handled on a personal basis between physicians. A registered nurse, experienced in coronary care, is on duty at all times and is empowered to defibrillate or pace at the discretion of the physician in each individual case. Such delegation has been given almost unanimously after initial weeks of hesitation.

Between 1 February, 1967, and 31 January, 1969, 289 patients were admitted to the coronary care unit for chest pain, arrhythmia or acute cardiopulmonary catastrophe. Of these, 117 were selected for the present study as meeting criteria for clear-cut myocardial infarction:

1. Satisfactory history with unequivocal EKG evidence of acute transmural infarction.

2. Satisfactory history with a changing ST-T pattern of subendocardial infarction and significantly elevated SGOT (greater than 50 units) in cases in which other causes for such changes could not be found.

3. Pathological evidence of recent myocardial infarction.

The remainder of the patients were eventually classified as coronary insufficiency syndrome, primary arrhythmia, acute pulmonary edema, simple syncope, hyperventilation syndrome, chest wall pain, or various abdominal conditions, etc.

Results

Of the 117 patients with unequivocal myocardial infarction, 94 were males. The average age of the group was 61, the men averaging 60 years and the women 65 years. The average length of stay in the moni-

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tored bed was 6.3 days for survivors. Eighty-seven of the patients were admitted to the unit within 12 hours of the onset of their pain and 61 were admitted within four hours of the onset of pain. Twenty-four of the patients died while still in the coronary unit and five died after transfer to the regular wards, giving an overall mortality rate of 25% and an in-unit mortality rate of 20.5%.

Careful review of the clinical histories of the 29 deaths revealed that only two could have been in any manner considered "unexpected," or negotiable. One developed bradycardia leading rapidly to ventricular fibrillation, and the other died suddenly following recurrence of chest pain (cardiac rupture?). It is interesting to note that only one case of successful defibrillation with eventual discharge took place in the coronary care unit, while during the same period, there were three successful resuscitations on the general wards (all four occurring during the second year).

It is important to point out that the gross mortality figures from the coronary care unit can easily be influenced by patient selection. Exlusion of patients in the above series who were in extremis by the time they reached the coronary care unit would have greatly improved the above results, while inclusion of those patients who were transferred to the unit after resuscitation attempts elsewhere in the hospital would have had the opposite effect. It seems, therefore, that the above 20% unit mortality, while not so low as reported from some units,[6] is an acceptable estimate of the inherent present mortality of acute myocardial infarction in an unselected population.

Review of the hospital records during a one year period between 1 February, 1965, and 1 January, 1966, prior to the opening of the coronary care unit, revealed 49 patients meeting the same criteria for myocardial infarction. This group had a similar age and sex distribution. Of the 49 patients, 15 died while in the hospital for an overall mortality of 30%.

Conclusions

1. Review of a two year experience in a coronary care unit in a community hospital without full-time house staff reveals that the unit is generally able to accomplish its intended goal, i.e., the prevention of "electrical" death in acute myocardial infarction.

2. A high degree of supervision and/or restriction of physicians admitting to the unit has not been necessary. No cases of dire neglect or gross mishandling of patients could be found. In addition, adoption of habits of aggressiveness by the medical staff as a whole has occurred quickly, consistently and informally without external pressure. Rapid cardioversion, delegation of responsibility to the nursing staff, appropriate response to premonitory arrhythmias and the maintenance of intravenous routes are examples of such habits. Continued self-education has been eagerly accepted by both the medical and the nursing staffs.

3. A high degree of administrative authority has not been necessary to maintain the proper utilization of the available unit beds. At no time has a physician whose patient needed constant monitoring been unable to arrange such admission to the unit by direct contact with his colleagues.

4. Secondary benefits to the community and medical staff, or "fallout," while difficult to quantitate have been evident. Examples of thi are increased professional and com munity pride in the hospital, a will ingness by physicians to have thei patient care reviewed, an increase enthusiasm and feeling of participa tion by the nursing staff, and a mor aggressive approach to cardiopulmo nary resuscitation in all cases of un expected death elsewhere in th hospital.

5. Because of the natural fluctu ation of case loads in such a unit i a community hospital, the coronar care unit has been used as an "in tensive medical care unit" without ap parent detriment to its primary func tion. This is a quite natural develop ment because of a concentration o nursing skills and equipment. Initia concern that this would conflict wit adequate coronary care did not prov justified.

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Seven principles of treatment are developed in the course of a thoroughgoing and concise discussion of the basic pathology and associated disease processes in patients suffering from cerebral vascular disease.

Principles of Therapy in Cerebral Vascular Disease*

MARK L. DYKEN, M.D.**
Indianapolis

BEFORE I discuss the principles of medical therapy, I would like to play a game. The reader is familiar with the terrible death toll caused by motor accidents. For a moment, stop and think about these deaths and compare them to the deaths caused by cerebral vascular accidents. Is the mortality the same or does one cause more deaths than the other? If you think there is a difference, estimate the degree. Keeping this comparison in mind, think again about motor accidents, and add to this group all other violent deaths, whether due to falls, fires, drownings, firearms, homicides, suicides, machinery accidents, poisonings by solids or liquids, poisonings by gases or vapors, etc. Now compare the mortality rate of this large group to that of cerebral vascular disease. If you have not thought about this before, Figure 1 may be impressive.[1] The annual death rate due to stroke is almost four times that of motor accidents and about two times that of all accidents. As the news media stress the problems of accidents, I will limit my presentation to cerebral vascular disease.

It will be impossible to exhaustively review the vast and oftentimes conflicting literature concerning the therapy of cerebral vascular disease. Unfortunately, many conflicting opinions concerning therapy and treatment programs are available, and one must read quite widely not to be prejudiced by a few articles. Although it will be impossible not to reflect some of my own prejudices, the attempt will be made to present the facts as objectively as possible.

Seven Main Principles

For practical purposes, I will discuss ischemic and hemorrhagic disease separately, but before I discuss either group, I must stress that treatment begins with diagnosis, and diagnosis begins with a satisfactory understanding of the functional anatomy of the brain, the usual distribution of the arteries, the basic pathological processes of the central nervous system, and how the central nervous system reacts to injury. To use this knowledge, a complete history and a physical and neurological examination are a necessity. The *first principle of therapy* is to *rule out diseases that mask as cerebral vascular disease.*

Although the major causes of ischemic disease are atherosclerosis either with or without thrombosis and cerebral embolism,[2] and the major causes of spontaneous hemorrhagic diseases are ruptured berry aneurysm or cerebral hemorrhage associated with hypertension,[3] rarer causes, some of which are treatable, can produce these conditions. Ischemic disease may be produced by such things as a tumor compressing an artery, septic embolus with early abscess formation, meningovascular syphilis, arteritis related to pyogenic or tuberculous meningitis, malaria, lymphoma, collagen disease, polycythemia, trauma to the neck, hematological disorders, dissecting aortic aneurysm, radiation, and tentorial, foramen magnum and subfalcial herniations.[2] Clinically spontaneous hemorrhagic disease may be produced by unrecognized trauma, anticoagulant therapy, erosion of a vessel by a tumor, arteriovenous malformation, mycotic aneurysm, collagen disease, blood dyscrasia, etc.[2] Therefore, the *second principle of therapy* is to *be aware of, diagnose, and treat the rarer causes of cerebral vascular disease* (especially those that are specifically treatable).

One must be aware that cerebral vascular disease may be associated with other diseases. Atherosclerosis of the vessels supplying other organs, e.g., the heart and kidneys, diabetes mellitus, hypertension, renal disease and heart disease are some of these.[4-12] These diseases must be recognized and treated for proper care of a stroke patient. The *third principle of therapy* is to *diagnose and treat associated disease.*

In addition to the first three principles of therapy, one must consider other conditions that might have precipitated the "accident." Cerebral infarction or ischemia may follow any condition that decreases the blood, oxygen or glucose supply to an area attenuated by atherosclerosis.[13-16] A cerebral infarction may be secondary to either a drop in blood pressure or embolic phenomena secondary to myocardial infarction. Orthostatic hypotension, blood loss, carotid sinus sensitivity, drops in pressure during anesthesia, or any condition producing a precipitous drop in blood pressure can cause an infarction.

* Partially supported by NIH Grant NB HE 06793.

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Severe anemia, hypoglycemia, or any condition associated with reduced oxygen-carrying capacity of the blood may contribute to the development of an infarction. Therefore, the *fourth principle of therapy* is to *diagnose and treat diseases that may precipitate a cerebral vascular accident.*

Only after one has adhered to the first four principles of therapy is one ready to discuss the treatment of the specific insult; and even at this point, we are not ready to talk specifically about ischemic and hemorrhagic disease. The complications of bed rest and inability to handle secretions causes most of the deaths in patients with cerebral ischemic disease and contribute significantly to those who die with intracranial hemorrhage. These complications include genitourinary tract infections, pneumonia, thrombophlebitis, decubiti, and other intercurrent infections. They may be largely prevented by intensive nursing care, careful maintenance of fluid and electrolyte balance, rigid adherence to good supportive therapy and immediate passive physical therapy.[17-18] In ischemic disease, unless contraindicated, active physical therapy should be started as soon as the patient can cooperate.[19-21] The physician must above all be a total doctor and use all of his training to guide his program and must recognize complications early and treat them vigorously. In patients who have language disturbances, personnel and relatives should be instructed in the importance of attempting to communicate with the individual so that there is stimulation from the environment that encourages the patient to regain skills lost by the insult.[22] Many physicians have become disillusioned by the failure of many types of so-called specific therapy that have been touted and have resolved themselves to the defeatist attitude that stroke is untreatable. I believe they are correct if by treatment they mean reading the *Physicians' Desk Reference* to find a specific

U.S.A. DEATHS (1966)	
CVA	204,841
Motor Accidents	53,100 (26%)
All Accidents	112,000 (55%)

INDIANA DEATHS (1965)	
CVA	6,171
Motor Accidents	1,535 (25%)
All Accidents	3,655 (59%)
Poisoning	
Suicide	
Homocide	

FIGURE 1

therapy after a laboratory report has made the diagnosis. To me, the greatest challenge and reward in therapy is to use medical skills to decrease morbidity and mortality by good total care of the patient and to prevent complications, or to recognize and treat them early. This is indeed a challenge to a physician. The *fifth principle of therapy in cerebral vascular disease* is to *devise a total treatment program to prevent, recognize and treat complications associated with bed rest.* The *sixth principle of therapy* is to *obtain maximum function of residual abilities.*

At this point, after the first six basic principles of therapy have been initiated, we are ready to discuss specific treatment. In this discussion, it will become obvious that, if all therapies that have been reported were indeed of value, there would be no need for this paper as cerebral vascular disease would be no longer a problem. Therefore, before the discussion begins, we must again stress proper scientific evaluation of proposed treatments.

Specific Therapy—Intracranial Hemorrhage

Subarachnoid Hemorrhage Related to Berry Aneurysm: Subarachnoid hemorrhage secondary to a ruptured aneurysm has been treated with hypothermia,[23-27] hypotensive agents,[28-32] carotid ligation,[33-38] and various types of intracranial surgical approaches.[39-49] Recently, a pilot study has suggested that epsilon aminocaproic acid, an antifibrinolytic agent, may be of value.[50] If one of these articles was selected at random, a casual reader might be convinced that it described the best treatment available. Unfortunately, this vast mass of literature has not been submitted to rigorous scientific evaluation, and as yet we do not know the ideal form of treatment. McKissock and his group were the first to perform a controlled scientific study.[51-52] A well-designed controlled cooperative study sponsored by the National Institutes of Health has been established to study bed rest, hypotension, carotid ligation and intracranial surgery.[53] Although many institutions are cooperating in this study, after five years no clear cut preference has been published by this group. We may assume after this length of time that the best treatment will not be too greatly different from the others, otherwise a decision would have been made earlier. It may be that no single form of therapy will be ideal for all locations of aneurysm and all time intervals after the initial bleeding. Epsilon aminocaproic acid is mentioned only in passing as it has not yet been submitted to rigorous controlled study. The data reported by Sahs from the National Institutes of Health Cooperative Study of Intracranial Aneurysms and Subarachnoid Hemorrhage revealed such an extremely poor prognosis for patients treated with hypothermia that further studies are probably not indicated.[32]

Cerebral Hemorrhage Associated with Hypertension: The mortality rate of this serious condition may exceed 90%.[17,54] In the acute stage intracranial surgery is of little value. Evacuation of an intracerebral hematoma is definitely indicated if the patient survives the initial episode and the hematoma is large enough to cause actual mass compression or

if it progresses.[51,52,55,56]

Meyer and Bauer evaluated hypotensive therapy during the acute stage by a controlled study.[28] They reported statistically significant decreases in mortality in the treated group. Therefore, it would seem that hypotensive agents should be used in this condition.

Although the outlook for therapy of cerebral hemorrhage related to hypertension is dismal, data from several sources indicate that the incidence of cerebral hemorrhage is decreasing and that this may well be related to antihypertensive drugs.[57-59] Aurell and Hood demonstrated a significant decrease in cerebral hemorrhage and an increase in the average age of individuals experiencing hemorrhage after the advent of good antihypertensive therapy.[58] One must be cautious in drawing conclusions as to cause and effect, but there may be a relationship. It is advisable to treat gradually, since a rapid drop in blood pressure may precipitate ischemic disease.

I will not discuss arteriovenous malformations and the rarer causes of intracerebral hemorrhage.

Specific Therapy—Ischemia and Ischemic Infarction

Cerebral embolism is usually secondary to extracranial disease. The diagnosis is based on the evidence of sudden cerebral dysfunction in an area supplied by an artery and the ability to demonstrate either a source capable of producing emboli and/or evidence of embolic phenomena elsewhere. Cerebral embolism may occur in association with atrial fibrillation or other arrhythmias, myocardial infarction with mural thrombus, acute or subacute bacterial endocarditis, heart disease without arrhythmia or mural thrombus, cardiac surgical procedures, nonbacterial thrombotic endocardial vegetations, paradoxical embolism in congenital heart disease, atherosclerosis of the aorta and carotid arteries, fragmentation of thrombi in cerebral arteries or in pulmonary veins, air emboli following trauma to lung or neck or following decompression and fat emboli associated with fractures of marrow bones.[2] The ideal treatment for this condition insofar as it practicable is preventive. In all cases, the primary condition should be treated. Although the causes of infarction may be different, the results of actual brain tissue death produce problems requiring similar treatment. Therefore, the specific treatment for the infarction of the brain will be discussed with ischemic disease associated with atherosclerosis.

Countless specific forms of treatment for ischemia and ischemic infarction have been reported. It will be impossible to review the vast number of types of therapy that have been reported as being ideal but have ultimately been proven to be of no value or dropped by general consensus. Some of these will be mentioned in passing and some in more detail.

Treatments Assumed to Increase Cerebral Blood Flow: Before Kety and Schmidt devised the nitrous oxide technic using the Fick Principle to actually measure cerebral blood flow, many drugs and procedures were advocated for this purpose. Such drugs as aminophylline, nitrites, iodides, adrenalin, benadryl, nicotinic acid, alcohol, and histamine were all proposed on this basis, but none actually increased cerebral blood flow.[60,61] At one time, bilateral stellate ganglion block was popular on the assumption that it alleviated cerebral vascular spasm and increased cerebral blood flow.[62-65] In most cases of ischemia, either with infarction or transient, vasospasm is not a major factor.[66,67] None of these drugs or procedures has been shown to be of any value in any scientifically valid study.

The most potent agent to increase cerebral blood flow is carbon dioxide. Some reasoned that since cerebral ischemic disease was related to decreased blood supply that carbon dioxide inhalation might be the therapy of choice.[68] A major defect in this reasoning is a failure to recognize that in an area of absent or decreased blood flow, the carbon dioxide tension is already much higher than could possibly be created artificially.[69] Hoedt-Rasmussen et al. reported a luxury perfusion syndrome, which was described as hyperemia in regions with an adequate local arterial pressure and with increased carbon dioxide tension.[70] Carbon dioxide therapy was tested clinically by Millikan. Although this was not a random study, it did compare a treated group to a comparable untreated group; he found no significant difference in results between the two groups.[71]

Papaverine increases cerebral blood flow.[72] Meyer and his group compared patients treated by intravenous papaverine with controls.[73] A significant functional improvement in the treated group was noted, but there was no difference in mortality. Unfortunately, although objective tests were used, the scorer was not blinded as to which group received the drug and which received placebo.

Steroids: Steroids were reported as producing excellent results in an uncontrolled study.[74] A controlled study was repeated, and the patients in the cortisone group actually had a trend toward increased mortality.[75] However, the exceptional patient with a large infarction with edema causing increased intracranial pressure might benefit from parenteral steroids.

Anticoagulants: Many papers have been written concerning the efficacy of anticoagulant therapy. To my knowledge at least five large well-designed controlled studies have been performed.[76-82] All five come to essentially the same conclusions: there tends to be an increase in mortality in all types of ischemic disease treated by anticoagulants on a long-term basis, and a decrease in the number of episodes of transient ischemic attacks and possible benefit

in evolving infarction was described. Despite this, Pearce et al. found no difference in transient ischemic attacks in their study of control versus treated groups.[83] Individual investigators have reported controlled studies where there is a suggestion of favorable results in very long-term therapy for six months to a year after infarction or in association with embolic phenomena.[84,85] It is apparent that if this therapy has any value at all, it is not clear-cut. My personal conclusions from these studies are that I will not treat a patient with infarction with anticoagulants at any time. I will consider treating patients with transient ischemic attacks if they are so frequent that they interfere with activities of daily living, and then only when the patient agrees to take the increased risk.

Fibrinolytic Agents: Although theoretically of value,[86] Meyer et al. showed that they were dangerous clinically.[87] They reported a significantly higher death rate in 37 treated patients as compared to 36 controls.

Estrogens: McDowell et al. in a controlled study using Premarin demonstrated that the treated group did worse than the controls.[88]

Hydrogen Peroxide: Urschel reported a single individual with basilar artery insufficiency treated with intra-arterial hydrogen peroxide.[89] Early angiographic and clinical improvement was maintained after a six month follow-up. Further studies are necessary.

Surgery: The value of surgical treatment of atherosclerotic lesions in the extracranial portions of the carotid and vertebral arteries is still in the process of evaluation. Some authors report the results of surgical therapy in many hundreds of patients and others in as few as one. Almost all are merely skilled technical feats, for as yet there is no scientific study which objectively compares the results of surgery and medical therapy.[90-95] Unfortunately, the criterion of re-establishment of the lumen in a diseased vessel and a good blood flow at the time of operation is not an adequate criterion of success. A cooperative scientifically valid study supported by the National Institutes of Health is in process to compare surgical versus nonsurgical treatment.[96] To my knowledge, no clear-cut preference between medical and surgical treatment has been reported to this date.

If isolated atherosclerosis in a single vessel precipitates disease, it is only a contributor since there is good evidence that in a healthy young individual a vessel may be occluded with no change in clinical findings.[33-38,97] Faris et al. performed transbrachial percutaneous angiograms on 43 healthy male prisoner volunteers and found that 53.6% demonstrated some type of arterial lesion, and 23.2% had more than one artery affected.[98] No significant difference from a group of 68 male patients with cerebral vascular insufficiency was noted. Although many of us think that extracranial vascular surgery may have a place, this has not been determined.

Clofibrate: Although the presence of elevated cholesterol and other lipids has not been clear-cut in patients with cerebral vascular disease, recently there has been some interest in the possibility that these drugs will decrease atherosclerotic disease. Acheson and Hutchinson reported a preliminary study comparing patients with cerebral vascular disease who received Clofibrate to a control group.[99] A total of 106 patients was studied. No significant difference was obtained, although there seemed to be a trend for decreased recurrence of disease in those treated. A double-blind controlled study might soon be initiated to evaluate the long-term benefit of this drug.

Hypotension: The dangers of a sudden drop in arterial blood pressure have been described, and the value of hypotensive medication in cerebral hemorrhage related to hypertension has been noted. Although at first it may seem inappropriate, we must now discuss hypotensive therapy in ischemic vascular disease. Meyer et al. have demonstrated in hypertensives that cerebral blood flow was increased by decreasing arterial blood pressure.[100] A double-blind controlled study has been initiated to compare patients with cerebral vascular disease who are treated by hypotensive agents with those who are not.[101] In 1964, John Marshall compared 39 hypertensive patients treated with hypotensive agents and compared these to 42 control patients.[102] All were treated after a non-embolic infarction. Statistical analysis revealed a significant decrease in further cerebral vascular accidents in men and a trend for a decrease in further accidents in women. These studies suggest that hypertensive patients who have ischemic cerebral vascular disease should be treated cautiously with antihypertensive medication. The drop in arterial pressure should be done gradually and maintained over long periods.

To conclude the discussion of specific therapy it seems obvious that the *seventh principle of therapy* is that *no treatment program that could conceivably be of harm should be initiated unless well-designed scientific studies have shown the treatment to be of value when tested by recognized statistical technics.*

Summary

The seven principles of therapy in cerebral vascular disease are:

First Principle: Rule out diseases that mask as cerebral vascular disease.

Second Principle: Be aware of, diagnose, and treat the rarer causes of cerebral vascular disease (especially those that are specifically treatable).

Third Principle: Diagnose and

treat associated disease.

Fourth Principle: Diagnose and treat diseases that may precipitate a cerebral vascular accident.

Fifth Principle: Devise a total treatment program to prevent, recognize, and treat complications associated with bed rest.

Sixth Principle: Obtain maximum function of residual abilities.

Seventh Principle: No treatment program that could conceivably be of harm should be initiated unless well-designed scientific studies have shown the treatment to be of value when tested by recognized statistical technics.

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Physician Manpower—"Telling It Like It Is"

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THIS is an age of increasing awareness of health services. Public concern about availability of care, and personnel to provide it, has never been greater. It matters little whether there is a real or imagined shortage of physicians—the average man on the street is convinced there is. Furthermore, he is often just as convinced that this shortage has been planned—a sort of "managed economy."

Facts and figures pertaining to the supply and utilization of physician manpower are available in abundance. Medicine has done a remarkably good job in keeping records. Yet, much of the information is scattered, provided from many sources, and all too frequently dull and statistical. Following is an attempt to present a broad picture with interpretation of the current status in the country as a whole.

The Numbers Game

Surprisingly enough, prior to 1963 there were several different "official" counts of the number of physicians in the United States. This confusion stemmed from a lack of agreement on who should, and who should not, be counted. Should interns and residents, retired doctors, military personnel, foreign physicians in the country for further training, and those in occupations other than delivery of health care be included? Obviously, to include or exclude all or some of these groups can make a considerable difference.



In 1963 the disparate forces were brought together and agreement was reached on methods of count. Since that time reports of various groups have tended to agree. This has resulted in marked correction in the tables published by some groups.

Still another factor contributing to the greater reliability of today's data has been the use of the computer. At the headquarters of the American Medical Association in Chicago, extensive data concerning each recipient of the M.D. degree are recorded on computer tape. These data may then be readily retrieved in a variety of forms and may be frequently updated.

Figures relating the *total* number of physicians in an area to the population are of little value and may be quite misleading. This is especially so in areas where there are unusually high numbers of military, industrial, or retired physicians, or those making up the staffs of medical schools.

On 1 January, 1968, there were 258,279 nonfederal, active physicians providing care to the U. S. civilian population according to the Public Health Service.[1] This figure includes 11,023 who hold the Doctor of Osteopathy degree in accordance with the P.H.S. practice of not distinguishing between the D.O. and the M.D. degree for most purposes. This total figure breaks down to 132 physicians per 100,000 civilians. The five states with the largest supply of practicing physicians per civilian population were, in order: New York (199), Massachusetts (181), Colorado (168), Connecticut (164), and California (161). In this ranking of the states, Indiana stood 37th (94).

It is a well-known fact that the problem of distribution of physicians ranks right alongside that of the total number. The U.S.P.H.S. has defined county population groups into five categories as follows:

(1) Greater Metropolitan—Counties in standard metropolitan statistical areas (SMSA) with a population of 1,000,000 or more.

(2) Lesser Metropolitan—Counties in SMSA's with populations of 50,000 to 1,000,000.

(3) Adjacent—Counties contiguous to one of the SMSA's above.

(4) Isolated Semirural—Counties neither in nor contiguous to a metropolitan area, but which have at least one incorporated community of at least 2,500 people.

(5) Isolated Rural—Counties which do not fall into any of the above classifications.

As might be expected, the ratio of physicians to consumers is nearly four times greater in the Greater Metropolitan areas than in the Isolated Rural areas, with the three intermediate groups falling between. In Indiana, the population is distributed largely among the three intermediate classifications. If the number of practicing physicians in Indiana is compared with similar population districts of other states, a remarkable similarity can be seen.

The dwindling number of general practitioners among the physician population is a source of concern to many people. The actual number who are providing this kind of medical service is obscure due to many factors. Some begin specialty training

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after several years of practicing general medicine while others who hold, or are eligible for, specialty rating do in fact practice as generalists. In any event, the Willard Committee reported in "Meeting the Challenge of Family Practice"[2] those who begin, and stay, in general practice has for some years been leveled off at 15 to 25% of the new entrants to the profession.

Both the report, "Meeting the Challenge of Family Practice," and another, "The Graduate Education of Physicians,"[3] were published by the AMA in September, 1966. Both stressed the need for preparation of more general (or "primary," "family," "front-line," etc.) physicians. A significant outgrowth of these efforts has been the formation of the American Board of Family Practice, formally approved on 8 February, 1969, as the 20th specialty board in medicine. It is to be hoped that this move will contribute to an increase in the attractiveness of this form of practice to future graduates.

Physician Production

There were 7,973 M.D. degrees awarded by 85 medical schools in the U. S. (including Puerto Rico) during the academic year 1967-68.[4] The University of New Mexico became the 85th degree-granting medical school that year with the graduation of its first class of 19 students.

The number of M.D. degrees granted has increased by 16% over the past decade during which time the nation's total population has increased by 12%. Figures for number of degrees are as follows:

Ten Years Ago	6,861
Five Years Ago	7,264
1967-68	7,973
Predicted—1968-69	8,075

A measure of the current expansion in medical education in this country can be gotten by looking at the first year enrollment figures. As recently as five years ago, 87 medical schools (including three offering basic sciences only) admitted 8,642 students. Last year 94 schools admitted 9,479 students. Four of these were new schools admitting students for the first time.

In the near future the increase is expected to accelerate both as a consequence of expansion of existing schools and the opening of additional new ones. Current predictions call for the enrollment to reach at least 11,000 beginning students by 1972-73.[4]

In 1959 the Public Health Service Surgeon General's Report, "Physicians for a Growing America,"[5] triggered nationwide interest in expansion of medical education opportunities. At the time, 1957-58 academic year, there were 81 four-year schools and four schools of the basic sciences. Development of new medical schools had lagged for 20 years. Two new schools were created in the decade of the 1930's, three in the 1940's, and six in the 1950's. Newly developed, and developing schools in the 1960's, with the year of enrollment of the first-year class, are as follows:

Kentucky	1960
New Mexico	1964
Rutgers—New Jersey	1966
Michigan State	1966
Arizona	1967
Hawaii	1967
Penn State—Hershey	1967
Brown	1967
U. California—Davis	1968
U. California—San Diego	1968
Connecticut	1968
Mt. Sinai—New York	1968
Texas—San Antonio	1968

In addition to these 13 new schools with students now enrolled, other schools which are well along in planning and/or construction, but without as yet firm dates for admission of their first classes, are:

Louisiana State—Shreveport
Massachusetts
Medical College of Ohio—Toledo
State University of New York—Stony Brook
South Florida

Student Attrition

For a variety of reasons, about one student in nine who begins medical school does not complete the requirements for his degree in the usual four years. Academic failure accounts for only about one-half of this loss. By no means all of those who drop behind are to be considered lost to medicine, or to health science careers. Some do ultimately finish in medicine and others in some field closely allied to medicine.

The simplest method of measuring the dropout rate is to record the total number of entering first-year students and subtract the total number receiving the M.D. degree four years later. This method has its shortcomings, however, as it cannot compensate for "drop-ins," either from academic graduate programs (those accepted for advanced standing), or transferees from foreign medical schools. However, such additions are few in number so the method does provide at least an index of loss. The only really accurate tabulation of dropout rate is by carefully following the progress of each individual through medical school, an expensive and time-consuming process. This has been carried out experimentally by the Association of American Medical Colleges and resulted in an interesting and worthwhile recent publication on the subject titled, "Doctor or Dropout?"[6]

There is evidence that after nearly a decade of increasing attrition among medical students, the loss has taken a downward turn in those classes graduated since 1965 and this trend shows evidence of continuing. Medical school faculties, aware of the enormous cost to society, are devoting much time and effort to careful selection and guidance of medical students in the interest of the production of more physicians.

The opportunity to attend a medical school is of paramount importance to those with proven ability and the desire. A look at how our citizens fared last year in this regard is of interest. Indiana ranks 12th in population among the states. The 251 stu

dents who entered medical school last year placed our state ninth in this respect, surpassing the larger states of Florida, Massachusetts, and North Carolina. Of these 251 students, by far the largest group, 206, began at Indiana University. The other 45 entered 20 schools, 14 privately supported and six tax supported.

For obscure reasons, not all students who are accepted for medical school actually matriculate. Last year, for instance, 385 more students were accepted than enrolled, and 10 of these were from Indiana. In all, 443 Hoosiers filed applications to enter medical schools in 1967-68, 261 were accepted, 251 began, and 182 were rejected. The 59% acceptance rate is better than that of the total U. S., where 9,702 of 18,724 total applicants were accepted, or 51.8%.[7] While it would not be correct to presume that *all* of those denied admission were fully qualified and should have been admitted, nevertheless there is ample evidence to support the concept that the nationwide pool of talent is sufficient to fill many more places than are currently available in U. S. medical schools.

Related to this winnowing, a sizable number of U. S. citizens annually seek a medical education abroad. According to the Institute of International Education, there were 2,325 U. S. citizens working toward degrees in medical sciences in foreign countries in 1966-67, excluding Canada. A few of these later return and receive advanced standing appointments in U. S. schools. A larger number return for internship and/or residency and, upon successful passage of the examination conducted by the Educational Council for Foreign Medical Graduates, become eligible for licensure by some state. Last year among the 9,326 total initial licenses issued in the 50 states, 187 were to U. S. citizens who were graduates of foreign medical schools.[8]

Minorities in Medicine

Medicine, along with other professions, is now being called upon to explain the unequal representation within its ranks of the various minority groups of the country. The answer usually given is straightforward enough and it is related to the high degree of selectivity afforded by two applicants for each available place in medical school. So long as admission continues to be based primarily upon the quality of the undergraduate academic record, little change can be expected.

While this system was acceptable in the past, it no longer suffices in today's society. Widespread concern now dictates that medical school admissions committees must weigh factors other than academic achievement in filling their classes. The problem takes on different form in various parts of the country but in general involves Negroes, Spanish-Americans, and American Indians.

While a very small percentage of black students have been graduated from the predominantly white medical schools in the past, by far the majority of M.D. degrees for Negroes have been earned at Howard and Meharry Colleges of Medicine. Both of these schools have long faced grave financial problems which have placed limits on their ability to attract and hold topflight faculty in the face of competition from other schools. This factor has likewise served to curtail expansion of facilities at those schools.

In an about-face, there is now fierce competition among U. S. medical schools for the well-qualified Negro student. All schools are seeking to improve their public image through enrollment of a greater proportion of Negroes. Generous scholarship support is available for the best of these and indeed bidding often runs high. This new pattern is, meanwhile, placing a heavy and awkward burden on Howard and Meharry. Not only are these schools now vulnerable for the better students but likewise for faculty. Are these two schools to be expected to assume responsibility only for those who cannot be accepted elsewhere? By what means can a larger pool of well-prepared Negro applicants be produced *now?* These, and other substantive issues concerning the black medical student, have been explored in depth in a recent book, "Negroes for Medicine."[9]

The imbalance between Negro population and Negro physicians is fairly ubiquitous throughout the U. S. The problem associated with the Spanish-American and the Indian populations varies greatly with regions of the country. The problems of attracting more of these students into medicine are similar, however, and in some areas of the country efforts are now being marshaled that are fully equal to those on behalf of the Negro student.

While women cannot be classified as a minority group in the general population, in this country medicine has always been overwhelmingly a male profession. This is not so in a great many other countries, and the number of women medical students and physicians in the U. S. has been on the upswing in recent years. While as individuals those women who in the past have entered the male-dominated profession of medicine have demonstrated a full capacity to perform well, their record as a group has been questioned. Their dropout rate from medical school has been higher than that for men and evidence shows that as a group the total service contribution of the female M.D. is only about one-half that of her male counterpart. The question then faced by admissions committees is: "Shall we take a woman when the chances that she will work full time in medicine are only 50-50, while with a man the chances are greater than 90%?" However, an overwhelming majority of women graduates report that they are contributing to medical care in part-time or full-time positions.

The number of women in medicine is clearly on the increase. A comparison of five years ago with last

TOTAL M.D. DEGREES

	U. S.		Indiana	
	Men	Women	Men	Women
1962-63	6860	405	148	5
1967-68	7332	641	193	16
5 Yr. Increase	472	236	45	11
	7%	58%	30%	120%

year, both for the U. S. and for Indiana, shows a marked increase in both the number and percentage of medical degrees granted to women.

The past, present and predicted roles of women in American medicine have been explored in some depth recently. An interesting and informative new book has resulted: "Women in Medicine," by Carol Lopate.[10] Both this book and "Negroes for Medicine," previously referred to, grew out of conferences and studies initiated and sponsored by the Josiah Macy, Jr. Foundation.

Financial Considerations

The state of residence can make an appreciable difference in the cost of attending medical school. In the 49 tax-supported schools, including three schools of the basic medical sciences only, and three of the developing schools, the average tuition charge was $657 last year for residents of that state. The range was from $206 (Hawaii) to $975 (Alabama). For comparison, the cost to a resident of Indiana at Indiana University School of Medicine was $700.

The state-supported schools, with two exceptions, all charged nonresidents appreciably more, the average fee being $1,240. The two exceptions were Hawaii and the Medical College of Georgia. The latter does not admit any nonresidents of the state so the question is academic. The range of charges was from $200 (Hawaii) to $1,900 (Michigan). Again for comparison, the charge to non-Indiana residents at I.U.M.S. was $1,600 (increased to $1,800 in September, 1968).

While all 49 state-supported medical schools give preference to residents of the state, and shift a higher proportion of the cost of his education to the student from elsewhere, only one completely closed its doors to outsiders last year—the Medical College of Georgia. Two others showed only a single admission from outside the state. At the other end of the scale, one state-supported school accepted 55 from elsewhere (Tennessee). In all, 85% of the 5,087 students accepted in 1967 by the 49 state-supported schools were from the home state.[4]

The privately owned medical schools are of necessity more heavily dependent upon student fee income for operating expenses than are the tax-supported institutions. In the 45 private schools accepting students last year, the average tuition was $1,876. With the exception of four, these schools made no distinction in the charge between residents of the home state of the school and those from other states. The four exceptions were Louisville ($1,375 vs. $2,000), Temple ($490 vs. $1,540), Pittsburgh ($450 vs. $1,500), and Penn State—Hershey ($390 vs. $1,050). In each of these schools some tax assist is provided by the state of residence, resulting in the preferential treatment of its citizens.

To an increasing extent the privately owned medical schools are seeking and receiving some tax assistance to help meet their rising operational costs. To date, only the four schools mentioned above have made any concessions to residents of the state of assistance, either in tuition differential or in selection preference. As a consequence, in the 45 private schools only 41% of the students admitted last year are from the state of residence of the school.

Due to financial stringencies, the private schools have been unable and/or unwilling to expand their classes as much as the publicly supported schools. This, together with the fact that nearly all of the newly planned schools will be tax supported, is upsetting the traditional balance of nearly equal public-private medical education. As recently as five years ago there were three more private schools than public. In 1967 that ratio was reversed, the public schools outnumbering private 49 to 45. The shift in numbers of students is more dramatic. In 1962 the tax-supported schools accepted only 174 more medical students than their private counterparts but by 1967 this had increased to 695.

It is significant that dropout from medical school is now seldom for financial reasons. Medical schools have for many years successfully raised considerable sums from alumni and friends to use in helping needy students. A few years ago a major effort to solicit funds from industry for this purpose on a nationwide basis resulted in the formation of the National Fund for Medical Education. Annual distribution of funds is made to each of the existing medical schools on a formula basis. Later, the American Medical Association formed the AMA Education and Research Foundation, which likewise undertook a nationwide solicitation of funds. The AMA has also instituted a most helpful program of guaranteeing private loans in order to facilitate ease of borrowing by medical students. Finally, and more recently, federal legislation has resulted in subsidy for medical education, both in the form of loans and grants.

As a result of these various financial aid programs, last year of the 34,528 students in all of the nation's medical schools, 18,960, i.e., 54.3%.

borrowed money. The average loan was $925. Ten thousand, one hundred forty-eight students—29.4%—received scholarship aid which averaged $819. Increasingly, financial means is not a determining factor in the selection of those who may, and those who may not, obtain a medical education.

Internships

Of the 853 hospitals offering internships in the U. S. in 1967-68, 419 were affiliated with a medical school, 434 were not. For several years there has been a gravitation toward the affiliated hospital internship program by the graduates of U. S. schools. The slack in the non-affiliated hospitals has been taken up by graduates of foreign schools. The latest year was no exception to this trend.

NUMBER INTERNS ON DUTY 1 SEPTEMBER, 1967

	U.S. and Canadian Graduates	Foreign Graduates
Affiliated Hospitals	5,557	938
Non-Affiliated Hospitals	1,949	1,975
Totals	7,506	2,913

The number of foreign graduates filling internships in this country has not changed markedly in the last few years. Forty-six percent of the 2,913 foreign graduates on duty on 1 September, 1967, were to be found in three Eastern states: New York, New Jersey, and Pennsylvania. Another 40% were located in the five states making up the *East North Central* region of which Indiana is a part. Yet, Indiana recorded only one foreign graduate intern among its total of 108 interns as of the above date. This has been a consistent pattern in Indiana with one foreign-educated intern in 1963, 1964, 1966, and 1967. There was none in 1965.

The salaries of interns have been traditionally low. A new trend has been apparent for the past few years, and shows signs of becoming permanent. This trend is shown in the following table:

ANNUAL INTERN SALARIES

	Affiliated Hospitals	Non-Affiliated Hospitals
1963	$3,053	$3,678
1965	3,578	4,071
1967	4,893	5,030

Medical Licensure

In 1967 a total of 20,074 licenses to practice medicine and surgery were issued by 54 legally constituted medical examining boards—50 states, District of Columbia, Guam, Puerto Rico, and the Virgin Islands. The majority of these 20,074 licenses were issued by reciprocity or endorsement to individuals already holding license in another state but 9,326 of the recipients represent new additions to the profession licensed for the first time. This represents an increase of 584 first-time licensees over the previous year. Among the 9,326 newly licensed physicians, 7,245 were graduates of U. S. and Canadian medical schools while 2,081 (22% of the total) were graduates of foreign medical schools (about one in five from the Philippines).

Insofar as a second license may be interpreted as a contemplation of relocation of practice, Indiana did not do well in 1967. In all, 232 licenses were issued by 34 other states to those previously holding Indiana license, while the Indiana license was issued by reciprocity to 126 licentiates of 31 other states. The states issuing the most licenses to Indiana license holders were: Ohio—56, California—43, New York—26, Illinois—16, and Wisconsin—10. (Florida does not license by reciprocity.)

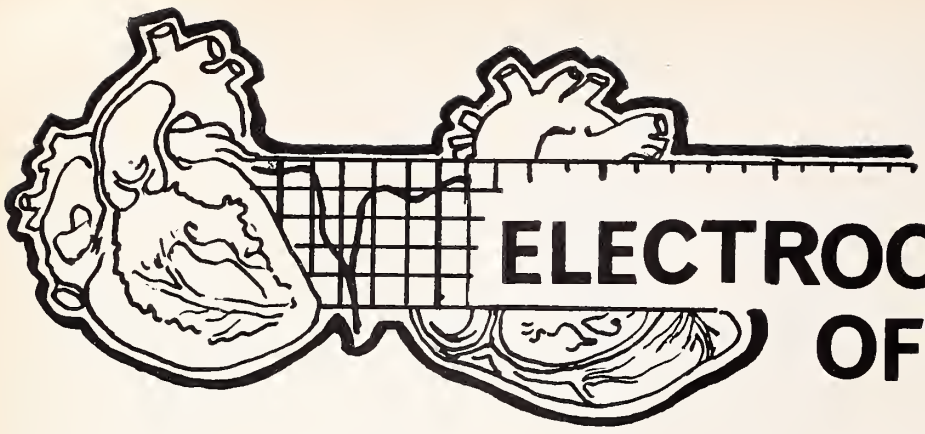
Among the 291 first-time licenses issued by the state of Indiana in 1967 were 181 to graduates of U. S. schools (177 from I.U.) and 110 to graduates of non-U.S. schools. It is significant to note that no graduate of the I.U. School of Medicine failed in his licensure examination.

Conclusions

It is apparent from the foregoing that, while some progress has been realized in the past decade in meeting the nation's needs for physician manpower, the effort must be greatly accelerated. Prospects now are that considerably more progress will be realized in the next decade. Evidence for a less spectacular growth in population now seems firm, but both expectation and complexity of health care can only increase. Can medicine and its foundation, medical education, meet the challenge and earn the right to continue to control their own destinies? There is much evidence for the affirmative.

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ELECTROCARDIOGRAM OF THE MONTH

Pacemaker Electrocardiography (1)

*CHARLES FISCH, M.D.**
Indianapolis

WITH the widespread use of artificial cardiac pacemakers, "pacemaker" electrocardiography has become commonplace. The recognition of the type of pacemaker is important and can, as a rule, be done by a careful interpretation of the ECG. Although some 30 different types of pacemakers are presently available, these can be grouped according to their characteristics as (1) fixed rate, (2) atrial synchronized, (3) ventricular demand with either QRS synchronized or QRS blocking properties. In the next few issues we will deal with the recognition of the type used as well as the various arrhythmias induced by the pacemakers.

The accompanying tracing is one of a demand, ventricular synchronized pacemaker. This type of pacemaker is characterized by stimulation of the heart in response to a pause (demand features) and a discharge of the pacemaker by a spontaneous ventricular activation (ventricular synchronization). At the beginning of the top strip the SA rate is slower than the preset rate of the pacemaker, the pacemaker responds to the demand, and the first five QRS complexes are induced by the stimulus artifact. This same is true of the last three complexes in the top row, first and last in the second row. In the middle of both rows the sinus rate exceeded the preset pacemaker rate and captured the ventricles with a prolonged P-R interval (0.42 seconds). Each QRS in turn discharges the pacemaker (ventricular synchronization) and a stimulus artifact is seen on the downstroke of the QRS. The sixth complex in the top strip and second in the bottom are intermediary between pure sinus driven and pure pacemaker driven complexes and represent "fusions." The fusion results from simultaneous activation of the ventricles by the P wave and stimulus generated by the pacemaker.

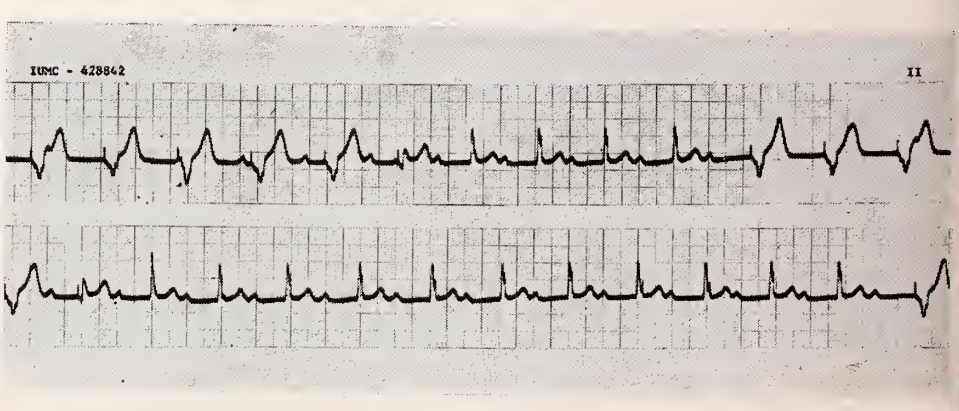


FIGURE 1
DEMAND, ventricular synchronized pacemaker. For details, see text.

* From the Krannert Institute of Cardiology, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.



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X-RAY CONFERENCE

Sequestration of the Lung

ERICH K. LANG, M.D.*
Shreveport, La.

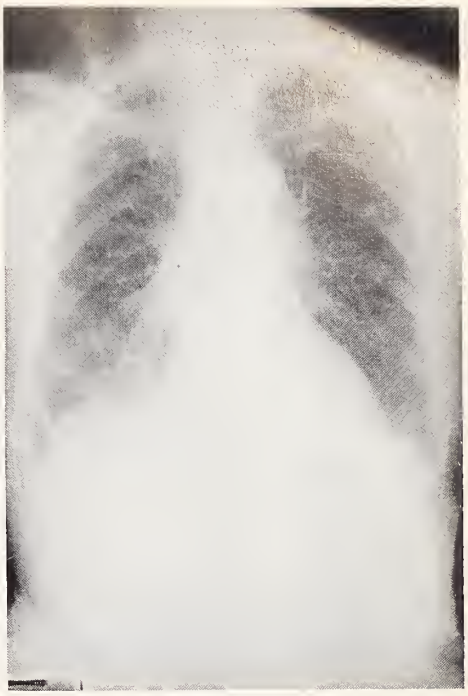


FIGURE 2
THE CHEST roentgenogram shows a honeycombed pattern in the right base.

THIS 37-year-old female was admitted for complaints of recurrent pneumonitides and hypertension. Physical examination was unremarkable with the exception of a blood pressure level of 210/140 mm. of mercury. Laboratory examination revealed elevation of the white count, positive STS and Treponema immobilization tests and eosinophilia. A chest roentgenogram revealed fibrotic strands in the right base and a "soap bubble" appearance suggesting bronchiectasis.

An aortogram was performed to assess the status of the renal arteries and a "harmonica-like" appearance of both renal arteries as well as the hepatic artery suggested fibromuscular hyperplasia of the media which most likely accounted for the observed hypertension. The most remarkable finding, however, was a highly tortuous vessel arising from the abdominal portion of the aorta at the level of T11-T12 and ascending into the right pleural space. This large and tortuous vessel appeared to supply the segment of the right lower lobe showing fibrotic and cystic changes. On basis of the anomalous vascular supply from the aorta, a definitive diagnosis of sequestration could be made.

Comment

Sequestra of the lung are usually located in the lower lobes and are characterized by atelectatic appearance or incomplete expansion and frequently sacular or cylindrical bronchiectases. A definitive diagnosis of a sequestrum can be made on basis of the telltale blood supply, directly from the aorta. Sequestra of the lungs frequently serve as a source of infection and should be surgically resected. Preoperative aortograms are of great value to identify the arterial blood supply, usually derived from the abdominal aorta through the diaphragm, which if unsuspected presents a severe menace during surgical exploration. ◄



FIGURE 1
NOTE the tortuous vessel (arrow) arising from the abdominal aorta and ascending into the right pleural space to supply a bronchiectatic segment of the right lower lobe (sequestrum). A "harmonica-like" appearance of the renal arteries (arrows) suggests fibromuscular hyperplasia.

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Biological Research

BIOLOGICAL research becomes more complex. At one time the basic material for an experiment was not difficult to find. Today if you want to mess around with polydeoxyribonucleotides it might take a year's hard work to make a spoonful of the experimental compound.

Ribosomal nucleic acid preparations, oxygen-18 labeled ethanol, or sphingolipids as examples, would all present the same problem.

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Guest Editorial

Now's the Time to Utilize Our Fresh Opportunities

ANY change in direction requires continuing energy. Otherwise it would not be a change, but a halt. This is true of objects in motion and also of men seeking progress.

Thus the Nixon Administration, if it is to advance along a new course, needs the support of those who wanted the change.

We are seeing new faces, new methods and a new political philosophy being introduced into national leadership. But how far the new Administration goes from here will depend on the force that backs it up.

The Administration can't be left to go it alone. Not in a time of enormous problems and conflicts such as we have today. And especially not when the trend toward more conservative principles, which President Nixon represents, calls for voluntary action as a substitute for more government.

Should businessmen relax now they would be leaving a vacuum in public affairs which pressure groups would quickly fill.

By seizing the more favorable opportunity of the present moment businessmen can be decisive in restoring the incentives and freedoms of choice which the individual American has lost in recent times.

The road ahead will, of course, be hotly contested. Those who favor more government intervention will never let up.

In this new phase of our struggle we will need to be united and organized.

To get the most out of your own effort you should channel it through an organization of like-minded businessmen which offers experienced leadership and a well-planned program of action.

This describes the function of your local and state chamber of commerce or your trade or professional association. Here you will be united through the National Chamber with the more active businessmen in every community and every line of business.

The legislative and other public affairs programs of the chambers and associations that have been in operation up to now are still basically good. The goals of our federation have not changed. We need only to shape our work for the new climate. **—Arch N. Booth, Executive Vice President, Chamber of Commerce of the United States, Washington, D.C.**

Editorial Notes . . .

The School of Aerospace Medicine is investigating a blood irradiator which may allow the application of a low dose of radiation to the blood over a long period of time without requiring prolonged hospitalization. The irradiator consists of an inert metal tube which can be grafted in place of a section of blood vessel. Attached to the outside of the tube is a strontium-90 radioisotope capsule. Radiation into the bloodstream is controlled by a small shutter which is driven by a Bulova Accutron watch movement. The timepiece can be externally actuated with a small magnet to control the radiation exposure rate. The irradiator is made by the Thermo Electron Corporation, a leader in the development of an artificial heart pump.

Hospital admissions during the first quarter of 1969 to 650 community short-term U. S. hospitals were increased by 2.1% over the same period of 1968. The number of persons 65 years of age and over admitted to the same hospitals during the same time were up by five percent and total expenses were up by 16.5%. Patients over 65 averaged a 13.4 day stay, those under 65 averaged seven days.

A compact nuclear-powered cardiac pacemaker designed to operate for at least 10 years is being tested in laboratory animals at the National Heart Institute. The long life of the device, if it proves feasible, will be a significant improvement. About 20,000 patients now have pacemakers and the number is increasing by 5,000 annually.

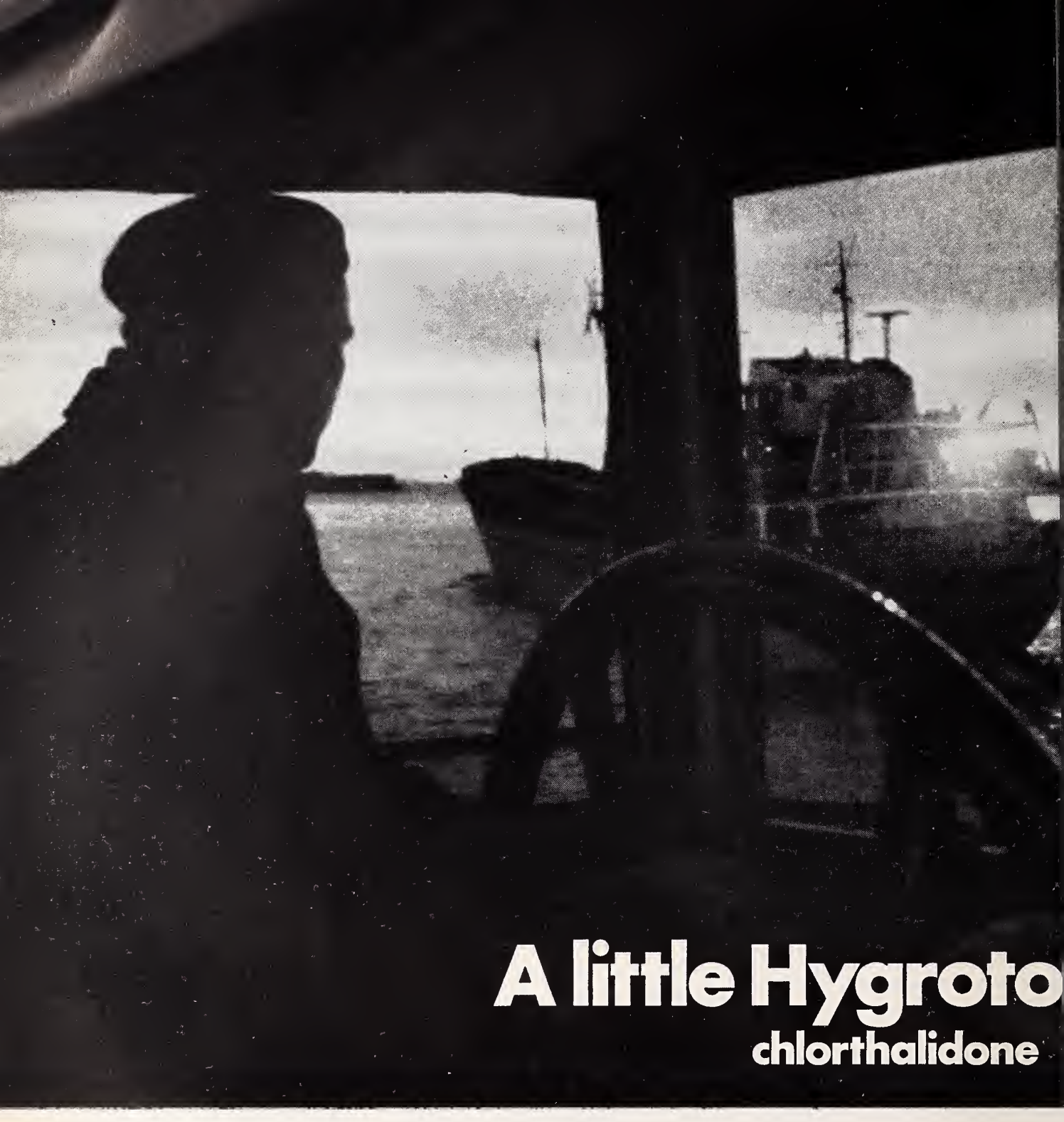
M.I.T. and Harvard, after two years of extensive study and discussion, are entering the major phase of a joint program designed to apply to medicine knowledge, insights and techniques from chemistry, physics, mathematics and the various fields of engineering, as well as from the management and social sciences. The effort will be aided by a $655,000 grant from the Commonwealth Fund. Included will be work on new patterns in biomedical education with new curricula, courses and teaching materials.

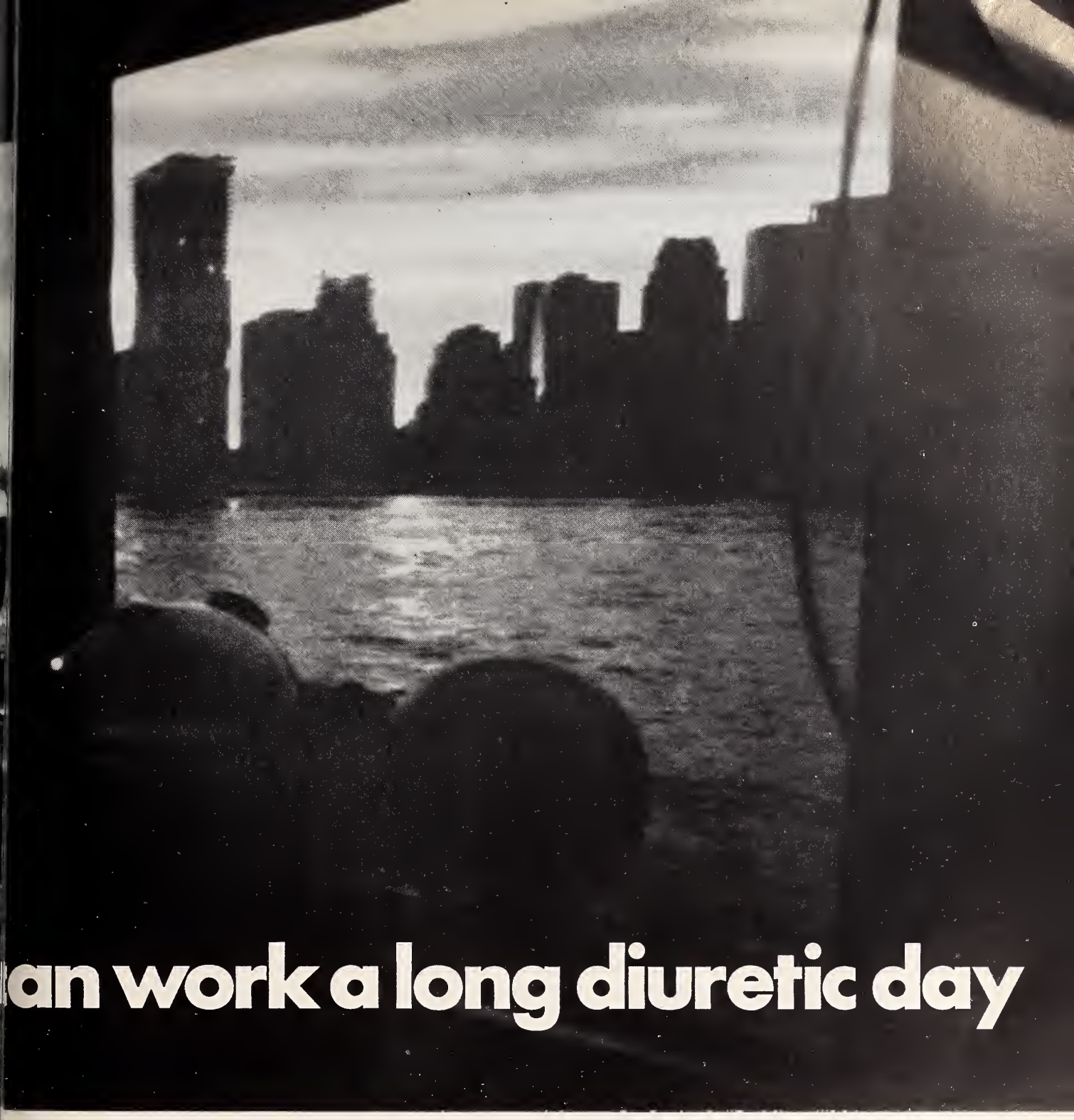
A miniature Ballistocardiograph has been developed by the United States Technical Development Company for use in research on small animals. It is one million times more sensitive than a human BCG and can monitor the heartbeat of a chick embryo less than three days in incubation without harm to the chick. It will also detect accelerations of animal heart tissue in culture.

Drs. Pollack, Gorman and Freda, codevelopers of the preventive for Rh isoimmunization, RhoGAM, are authors of the chapter on "Prevention of Rh Hemolytic Disease" in *Progress In Hemotology*, Vol. 6, recently published by Grune & Stratton. They stress that a negative Kleihauer test is no guarantee that the mother will not become Rh sensitized, since about half of mothers who do become immunized fall into this group. They also recommend use of the preventive in all abortions or miscarriages even though the Rh type of the fetus cannot be determined.

As distressing as the motor vehicle death rate is in the United States, it is exceeded by Japan, Australia, New Zealand, Canada and seven European countries. The rate, for instance, of deaths per 100 million vehicle miles is almost four times as high in Japan. The U.S. has more autos per 1,000 population (495) than any other country and has approximately the same vehicle death rate per 100,000 population. But when the miles traveled are figured in, our rates are the best, even though many times too high.

The University of Cincinnati Medical Center houses and cares for 14 species of animals which are used in medical research. Eight veterinarians comprise the largest veterinary staff of all U.S. medical centers. They have received a federal grant of $87,761 to cover a three-year study of the causes of spontaneous diseases in laboratory animals, a problem which plagues all animal research projects. Upper respiratory infection will be the principal subject. ◄


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ygroton, chlorthalidone, can cause side effects. And it's contra- dicated in hypersensitivity to the drug and severe renal and epatic diseases.

neck the prescribing information. It's summarized on the next page.

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chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic diseases.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.

(B)46-230-E

For full details, please see the complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

HY-6674

The Woman's Auxiliary

REPORTS TO ISMA

"Summertime and the living is easy."

When Gershwin wrote those words he wasn't referring to the officers and chairmen of the Woman's Auxiliary to the ISMA.

On June 18th at the ISMA building we met for a 1669-70 "Planning Session." Our attendance was almost 100% and all were both enthusiastic and sincere. Primarily we discussed the Area Workshops to be held for three consecutive days in September.



The dates, places and presiding vice presidents are as follows:

September 16, 1969—Evansville, Indiana—
Mrs. Abner P. Bennett
September 17, 1969—Indianapolis, Indiana—
Mrs. Willis W. Stogsdill
September 18, 1969—Fort Wayne, Indiana—
Mrs. Philip L. Smith

At these workshops we want to see YOUR WIFE! They are planned so no one has to travel a long distance, and since EVERY AUXILIARY MEMBER is invited, no one has to come alone.

The program planned will make auxiliary members more knowledgeable in regard to the challenges facing the medical profession, the unmet health needs of our state and communities and the legislation action needed.

None of these programs are new but the state officers and chairmen realize that no one keeps up his enthusiasm automatically. Enthusiasm must be nourished with new actions, new aspirations, new efforts and new vision.

Under the direction of Mrs. David Goldsmith, the 1969-70 *Work Book* is being compiled. Our aim is to have it ready to distribute to the county auxiliary officers at the September meetings.

Won't you remind your wife to attend? One of the objectives of our auxiliary is to cultivate friendships among physician's families. The Woman's Auxiliary State Family will be waiting to greet her.

Sylvia Schneider

This is the first of a series of articles on Medicaid about which so much has been written and said, good and bad.

Medicaid in Indiana

*WILLIAM R. STERRETT**
Indianapolis

ENABLING legislation for Title XIX of the Social Security Act (Medicaid), Chapter 274, Acts of 1969, was passed by the Indiana General Assembly to be effective January 1, 1970. This should not be confused with Title XVIII of the Social Security Act, which is a contributory insurance program administered by the federal government. Both of these amendments were passed in 1965 by the Congress of the United States, but Title XIX (Medicaid) is administered at the state level by the State Department of Public Welfare in Indiana, and financed jointly by the federal and state governments. No county money is involved. Chapter 274 is not the same bill that was introduced in 1967 and vetoed by the Governor at that time. It provides little more in the scope of medical services and the coverage of individuals than the present program of medical assistance, which covers all medical services in most counties. The great change will be in the way the program is administered.

Medicaid will be administered by the State Department of Public Welfare with the county departments of public welfare as agents. Rules and regulations for administration are now being developed. After January 1, 1970, payment will be made by a carrier, yet to be named, as in Medicare. Claims for medical services will be submitted on forms provided by the carrier. Identification cards will be provided by the carrier to all persons found eligible by the county departments of public welfare. The providers of medical services will continue to be responsible, however, for ascertaining continuing eligibility from the county department of public welfare if there appears to be any question.

A broadly representative Medical Advisory Committee, mandated by both federal and state legislation, started functioning July 1, 1969. You will be pleased to know that the first appointment to be confirmed was Maurice E. Glock, M.D., whose name was suggested by the Indiana State Medical Association to represent the physicians of Indiana on this committee. We are very pleased to have Dr. Glock accept this responsibility as he has served most capably for several years as a member of the Medical Advisory Committee for Medical Assistance for the Aged at the State Department of Public Welfare. The other members of the Medical Advisory Committee, as mandated by law, are one representative each from the following organizations:

Indiana State Chapter of the American Academy of Pediatrics
Indiana Hospital Association
Indiana Dental Association
Indiana State Psychiatric Association
Indiana State Osteopathic Association
Indiana State Nurses Association
Indiana State Licensed Practical Nurses' Association
Indiana State Podiatry Association
Indiana Association of Licensed Nursing Homes
Indiana Optometric Association
Indiana Pharmaceutical Association
Indiana State Chiropractic Association

In addition there are two members appointed by the Governor to represent the citizenry of Indiana, one person appointed by the Lieutenant Governor to represent the Senate, and one person appointed by the Speaker of the House to represent the House of Representatives. The function of the Medical Advisory Committee is (quoting the U. S. Department of Health, Education and Welfare), "to contribute specialized knowledge and experience and provide a two-way channel of communication with the individuals, organizations and institutions in the community, that, with the Administering Agency, provide and/or pay for medical care and services." ◄

* Administrator, Indiana Department of Public Welfare, 100 N. Senate Ave., Indianapolis 46204.



DAY BY DAY WITH THE F.D.A.

16,800 pounds of frozen raw scallops imported from Canada were embargoed at Boston when it was found that the entire shipment had been treated with chlortetracycline. The antibiotic was intended as a preservative but has not been recognized by the FDA as effective and safe for this purpose.

* * *

Two sunburn medications, "Kool 'N' Tanburn" and "Speed Tan" have been seized in large quantities because of the extravagant and unsubstantiated claims made on the labels. Such sales pitches as "effective to kill the pain of sunburn," "causes the skin cells to reproduce two or three times faster than normally," and "contains skin-growing vitamins" were enough to undo the products. A broad hint that the lotion would prevent skin cancer was the clincher.

* * *

Cross contamination during shipment continues to be a problem. $2,430 worth of food was recently ruined by leaking drums of trichlorobenzene in a mixed cargo. Another type of food contamination was located in Chicago in the form of a railroad car of lettuce which assayed 9.1 parts per million of DDT.

* * *

Ammonia-containing defensive vials, manufactured as aids against muggers, have been ruled off the market because the labels do not bear warnings required by the Federal Hazardous Substances Act.

* * *

High dieldrin residues in eggs are probably due to excessive use of aldrin as an insecticide powder in and around hen houses. One is the degradation product of the other.

* * *

Italian pear brandy imported at San Francisco was removed from commercial trade channels when excess amounts of methyl alcohol were discovered.

* * *

A restaurant in Allentown discovered, in time, that a powder assumed to be a food ingredient was actually phenobarbital powder, which should have been delivered to a chemical company in the same town.

* * *

Eleven million pounds of frozen fish were exposed to the elements when a 300-foot section of a cold storage warehouse was blown out by an ammonia gas explosion. Thirty-five fish processing firms, all food inspecting services and some 200 refrigerated trailer trucks worked around the clock in winter weather to inspect, salvage what was salvagable and destroy what was not. A below freezing cold spell for six days got the project off to a good start. Two million pounds were disposed of by dumping them into the sea on an outgoing tide.

* * *

FDA's Atlanta District Office and the Florida Department of Agriculture are establishing a collection of beans and other seeds which may be poisonous to man. Decorative beans are frequently imported from Central and South America and the Caribbean. Object is to avoid any future "jequirity bean" episodes.

* * *

Cases of medicinal bitters salvaged from a steamboat wreckage of 1865 may be used to determine the normal background radiation of products manufactured in the preatomic era. The ship was covered with some 30-40 feet of slit when found in the Missouri River.

* * *

Honey was found to be toxic to humans and upon analysis, andromedotoxin, which the bees had obtained by feeding on mountain and sheep laurel, was identified as the culprit. Typical symptoms were breathing difficulty, blurred vision, slight paralysis of extremities and nausea. Usually in the region affected the bees feed on fireweed which makes good honey. When the fireweed does not blossom, laurel honey is the result. The substance is apparently harmless to bees. ◄



Interest In ISMA Preceptor Program Continues to Grow

SINCE the advent of the current ISMA preceptorship program, many applicants have written to inquire about the purposes and mechanics of the program. How does the program work, what is expected of the preceptor, what is the aim of the program? These are a few of the questions that are asked.

We, on the Commission on Medical Education, feel that there are some things a student cannot be taught in medical school. Medical schools are excellent places to study the science of medicine, but to a lesser extent, the art of medicine.

The preceptorship program is meant to offer the medical student the opportunity to spend six weeks with a physician actively engaged in the private practice of medicine, and preferably the family practice of medicine. During this period, the student will have time to get to know his preceptor as a person, as well as a physician. He may be exposed to the subtleties of reassuring the expectant mother, of quieting the frightened child, of comforting the incurable.

And what of the business problems that go with conducting a practice? How do you run an efficient office? Very few medical students are natural born business men; if they were, they wouldn't be in medical school. How do you get the right kind of office help? How do you use them efficiently? What duties can be delegated to the office nurse? How do you keep accounts from becoming delinquent? How do you handle delinquent accounts? What have you learned about keeping the appointments running on schedule? What kind of records are important to keep on your patient?

There are clinics and outpatient services at the medical school to be sure, and the medical student is well versed in the management of leukemia, diabetes and tuberculosis. But what of the patients with bee stings, nail wounds of the foot, chronic headache, heartburn, chronic backache, dog bites, and a hundred and one things students don't see in the outpatient department?

What does the community expect of the physician? How does the busy doctor work in the Rotary, Kiwanis, Lions, church activities, Little League, P.T.A., United Fund drive, school activities, etc.? What kind of family life does the busy doctor have?

There are so many aspects of the practice of medicine that can be learned from a preceptor. They cannot be learned in medical school.

Currently, selected senior medical students are serving six-week periods, in lieu of time they would ordinarily spend on outpatient services at the medical center, with volunteer preceptors throughout the state. These preceptors are men engaged in the family practice of medicine. These students become the preceptor's shadow during this six-week period, sharing all his professional service, and family activities. It is not the primary purpose of the program to provide didactic teaching of the same type used in medical school, rather it is to provide an exposure to the family practice of medicine, to the everyday problems which confront the family physician. It is to broaden the medical school curriculum, to expose the student to an aspect of medical practice which it is not possible to present in the medical school environment.

What is required of a preceptor? That he be of good character, that he be interested in sharing his experience with a beginner; and that he be enthusiastic. What about living conditions for the student? If possible, the best solution would be for the student to live in the preceptor's home. Room, board, and laundry should be provided for the student. If the student is living with his preceptor, he goes on house calls, he hears the phone ring at night, he lives a physician's life for six weeks.

In no case should the student act as a replacement for his preceptor—nor should he expect to do work his preceptor would ordinarily do. The student is an observer. To be sure, there is no objection to his listening to a chest with his preceptor, checking a pelvis, or going through any other examination with his preceptor; this is encouraged, but such examinations should be a joint activity, or at least closely supervised.

It is a real sacrifice for any doctor to act as a preceptor, but students and physicians alike who have already participated in the program, feel that this has been an invaluable experience for them.

We do not feel that the program should be diluted by farming the student out to several doctors in a community for a week at a time, or two weeks at a time. We feel that the personal relationship established between the doctor and the student during this six-week period is an important part of the program.

It is the hope of the commission, he Indiana State Medical Association nd the Indiana University School of ledicine that through this preceptor- hip program, today's medical stu- lent may be better prepared to enter he private practice of medicine, and o deal effectively with human illness.

The Commission of Medical Edu- ation and Licensure is presently up- lating its listing of preceptors. For he information of ISMA members, he commission is listing below those vho are presently approved as pre- eptors under the program.

Reapplications for preceptorships ire requested as this list is periodi- ally reviewed by the preceptor screening committee. For those who ire interested in applying, the appli- cation accompanying this article may be used.

Applications should be sent to:
William A. Ringer, M.D.
% Indiana State Medical Association
3935 N. Meridian St.
Indianapolis, Indiana 46208

Preceptor Screening Committee
Commission on Medical Education and Licensure
Indiana State Medical Association
3935 North Meridian Street
Indianapolis, Indiana 46208

1. Name .....
2. Address .....
3. County Medical Society .....
   - A. Population
     - City .....
     - County .....
4. Medical School and Date of Graduation .....
5. Number of Years in Present Community .....
6. Type of Practice .....
   - A. Solo .....
   - B. Partnership .....
   - C. Group .....
7. Hospital Affiliation .....
8. Church Affiliation .....
9. Community Activities .....
   .....
10. Housing Facilities
    - Single student .....
    - Married student .....

Comments:

PHYSICIANS WHO HAVE SERVED AS PRECEPTORS SINCE JANUARY 1, 1966 OR HAVE BEEN RECENTLY APPROVED

Earl W. Bailey, M.D.
212 Fifth Street
Logansport, Indiana

Eldon Baker, M.D.
109 South Union
Delphi, Indiana

Robert E. Bahr, M.D.
3217 Lake Avenue
Fort Wayne, Indiana

Margaret A. Bassett, M.D.
Thorntown, Indiana

Neal Baxter, M.D.
306 E. Fifth Street
Bloomington, Indiana

Norman E. Beaver, M.D.
165 W. Water Street
Berne, Indiana

David C. Beck, M.D.
135 South Illinois Street
Monticello, Indiana

James Black, M.D.
Brownsburg, Indiana

Fred Blix, M.D.
Ladoga, Indiana

Barton C. Bridge, M.D.
Jefferson Square
Lafayette, Indiana

George E. Brown, M.D.
374 South Madison Avenue
Greenwood, Indiana

Earl E. Brown, M.D.
100 North Madison Street
Greenwood, Indiana

Franklin A. Bryan, M.D.
512 Medical Center Building
Fort Wayne, Indiana

Daniel H. Cannon, M.D.
1203 E. Spring Street
New Albany, Indiana

Irving Cohen, M.D.
645 East Main
Plainfield, Indiana

Eli Coats, M.D.
Box 300 C, R. R. #8
Indianapolis, Indiana

James Cortese, M.D.
435 South East Street
Indianapolis, Indiana

John R. Coughenour, M.D.
534 Turtle Creek, North Drive
Indianapolis, Indiana

Jean Creek, M.D.
1920 East Third Street
Bloomington, Indiana

Wilson Dalton, M.D.
117 W. Washington Street
Shelbyville, Indiana

David Dietz, M.D.
2810 Ethel Avenue
Muncie, Indiana

Ted S. Doles, M.D.
Middletown Medical Clinic
613 North 10th Street
Middletown, Indiana

Ramon Dubois, M.D.
23 North 25th Street
Lafayette, Indiana

Drs. Joseph and Betty Dukes
Dugger, Indiana

Ross L. Egger, M.D.
Middletown Medical Clinic
613 North 10th Street
Middletown, Indiana

Forrest Ellis, M.D.
241 Norris Avenue
North Vernon, Indiana

William E. Freeland, M.D.
12 E. Boehringer
Batesville, Indiana

Richard L. Glendening, M.D.
420-A High Street
Logansport, Indiana

Sidney R. Goldstone, M.D.
535 W. 35th Street
Gary, Indiana

Noel Graves, M.D.
Vevay, Indiana

James M. Hampton, M.D.
530 North Michigan Street
Argos, Indiana

N. Harvey Himelstein, M.D.
3500 Lafayette Road
Indianapolis, Indiana

Max Hoffman, M.D.
416 Union
Covington, Indiana

E. L. Hollenberg, M.D.
210 South Market Street
Winamac, Indiana

Irwin S. Hostetter, M.D.
115 North Cherry Street
Muncie, Indiana

James B. Johnson, M.D.
105 East Washington Street
Greencastle, Indiana

David G. Jones, M.D.
1504 North Madison
Anderson, Indiana

Robert Kinneman, M.D.
1038 North State Street
Greenfield, Indiana

James M. Kirtley, M.D.
1500 Darlington Avenue
Crawfordsville, Indiana

William A. Kleifgen, M.D.
446 W. Pontiac Street
Fort Wayne, Indiana

John Kolettis, M.D.
6111 Harrison Street
Gary, Indiana

John E. Krueger, M.D.
5717 South Anthony
Fort Wayne, Indiana

Richard J. Laker, M.D.
2407 Fair Oak Drive
Fort Wayne, Indiana

David J. Landon, M.D.
Union City, Indiana

Robert M. LaSalle, Jr., M.D.
645 North Spring Street
Wabash, Indiana

Kenneth M. Lehman, M.D.
Topeka, Indiana

Harold M. Manifold, M.D.
1920 E. Third Street
Bloomington, Indiana

C. X. McCalla, III, M.D.
Box 151
Paoli, Indiana

Donald L. McKinney, M.D.
North Main Street, Box 398
Otterbein, Indiana

Michael Monar, M.D.
Sixth and Main Streets
Rockport, Indiana

Thomas E. Moran, M.D.
7210 Madison Avenue
Southport, Indiana

George Morrison, M.D.
209 Fourth Street
Lawrenceburg, Indiana

Philip R. Myers, M.D.
1002 Lincolnway West
South Bend, Indiana

George Ostheimer, M.D.
R. 5, Sunnyside Drive
Martinsville, Indiana

T. Neal Petry, M.D.
111 East Franklin Street
Delphi, Indiana

Warren H. Pike, Jr., M.D.
Hobart, Indiana

George Poolitsan, M.D.
407 North Walnut Street
Bloomington, Indiana

C. A. Rau, M.D.
2600 Sandcrest
Columbus, Indiana

Eugene Rifner, M.D.
R. R. #1
Van Buren, Indiana

Glynn A. Rivers, M.D.
625 West Adams Street
Muncie, Indiana

James S. Robertson, M.D.
304 North Walnut
Plymouth, Indiana

Robert Robinson, M.D.
401 E. Fourth Street
Bloomington, Indiana

Malcolm O. Scamahorn, M.D.
Pittsboro, Indiana

William E. Schoolfield, M.D.
260 S. Maple Street
Orleans, Indiana

Robert Seibel, M.D.
Nashville, Indiana

Paul Siebenmorgen, M.D.
1024 South Sixth Street
Terre Haute, Indiana

Stephen D. Smith, M.D.
Knightstown, Indiana

William L. Strecker, M.D.
1024 South 6th
Terre Haute, Indiana

M. Reed Taylor, Jr., M.D.
Howe, Indiana

George M. Underwood, M.D.
Jefferson Square
Lafayette, Indiana

Thomas Walker, M.D.
R. R. 1, Box 93A
Brownsburg, Indiana

Richard M. Weisner, M.D.
Eaton, Indiana

John Woodbury, M.D.
Davis Clinic
Marion, Indiana

Robert O. Zink, M.D.
722 W. Main Street
Madison, Indiana

About Our Cover

This month we salute the general practitioner—the front-line doctor in the war on disease and disability from the patient's standpoint. For courage and stamina, he has no equal.

The demands of the profession and the demands of the public on him are ever-increasing. A few GP's are throwing in the sponge, either turning to a specialty or not accepting new patients. Medical schools are not training general practitioners, and students are not electing general practice because the demands of the public and the demands of the schools and profession are intolerably heavy.

The human being longs for certainty in an uncertain world. Doctors are human beings and it is certainly more certain all the way around in a specialty.

The public clamors for more and more medical services. Modern technology makes possible more and more medical services and more comprehensive services. The challenge is to correlate the demand with the supply by using technological advances which will make this possible. This requires the courage, imaginative qualities and stamina that are the common denominator of the general practitioner.

With the establishment of the American Board of Family Practice, increased loans to students who will practice for a specified time in rural areas, increasing awareness of medical schools of just what general practice is and the developing technology to conserve the doctor's time and efficiently provide information, medical schools, medical societies, the AMA, the American Academy of General Practice and the federal government are cooperating to aid more physicians to graduate, and particularly to make the challenge of general practice or family practice more palatable and attractive.

Rapidly changing advances in medicine and technology, in almost every aspect of health care, offer the solutions as well as some of the problems in the challenge of general practice. With greater understanding, maximum utilization of ever-changing technology, greater appreciation of the unique opportunities of general practice, the day may return when the general practitioner can sit down with his patient and meaningfully guide him through the maze of modern medicine to the greater satisfaction of both the patient and the doctor.

This is the challenge of general practice.

Convalescing . . . but still a long way to go. Anxiety can make it even longer.

Convalescence following medical or surgical procedures may be almost endless to an anxious patient. And, indeed, anxiety with some patients actually retards progress—for example, by inducing insomnia and reducing cooperation.

As physicians have found during nearly 15 years of widespread use, Equanil may be a beneficial part of aftercare. It helps relieve anxiety and tension, thus often aiding your primary therapy.

Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

EQUANIL®
(meprobamate)

Wyeth®

Wyeth Laboratories Philadelphia, Pa.

Photo professionally posed.



A Banner Year for Blue Shield

(One of a series prepared by Blue Shield)

The year 1968 was a milestone in the history of the Blue Shield movement.

Sweeping changes affected both the benefits offered Blue Shield members and the way physicians are being reimbursed for covered medical services.

Two historic moves were made during 1968 that expanded Blue Shield's capacities. Both were made during a special meeting of the National Association of Blue Shield Plans last October.

First, aiming at better service for both the public and the medical profession, Blue Shield adopted the requirement that every Plan must make available a program for covered services based on physicians' usual, customary and reasonable fees, as recommended by the American Medical Association.

Second, in response to a growing awareness by public and medical profession alike for broader health care benefits, Blue Shield adopted the requirement that all Plans offer a comprehensive scope of benefits by April, 1969.

These two proposals mean that Blue Shield can now offer uniform benefits to national account members across the country.

The prepayment movement chalked up other outstanding records during the year.

* The 82 Blue Shield Plans in the U.S., Canada, and Puerto Rico reported an increase of 1.25 million members, now serve more than 77.3 million persons in the payment of medical and surgical care expenses in underwritten and government programs—like Medicare and Medicaid.

* Medicaid or Title 19 programs for the medically-indigent are being administered by 15 Plans, involving more than three million persons.

* Blue Shield recorded its first full year of serving more than 1.5 million steelworkers and their families in an expanded health care program of paid-in-full benefits, involving uniform benefits in 38 Plans across the country.

* The American Medical Association and the National Association of Blue Shield Plans established a joint liaison committee to bring more closely together the objectives of medicine and prepayment and to help iron out problems that might arise between local Plans and local medical societies. ◀

SCIENTIFIC EXHIBIT APPLICATION FORM

Committee on Scientific Exhibits
Indiana State Medical Association
3935 N. Meridian Street
Indianapolis, Indiana 46208

Please send me an application form for a Scientific Exhibit at the ISMA Annual Convention, October 13-16, Indianapolis, Indiana.

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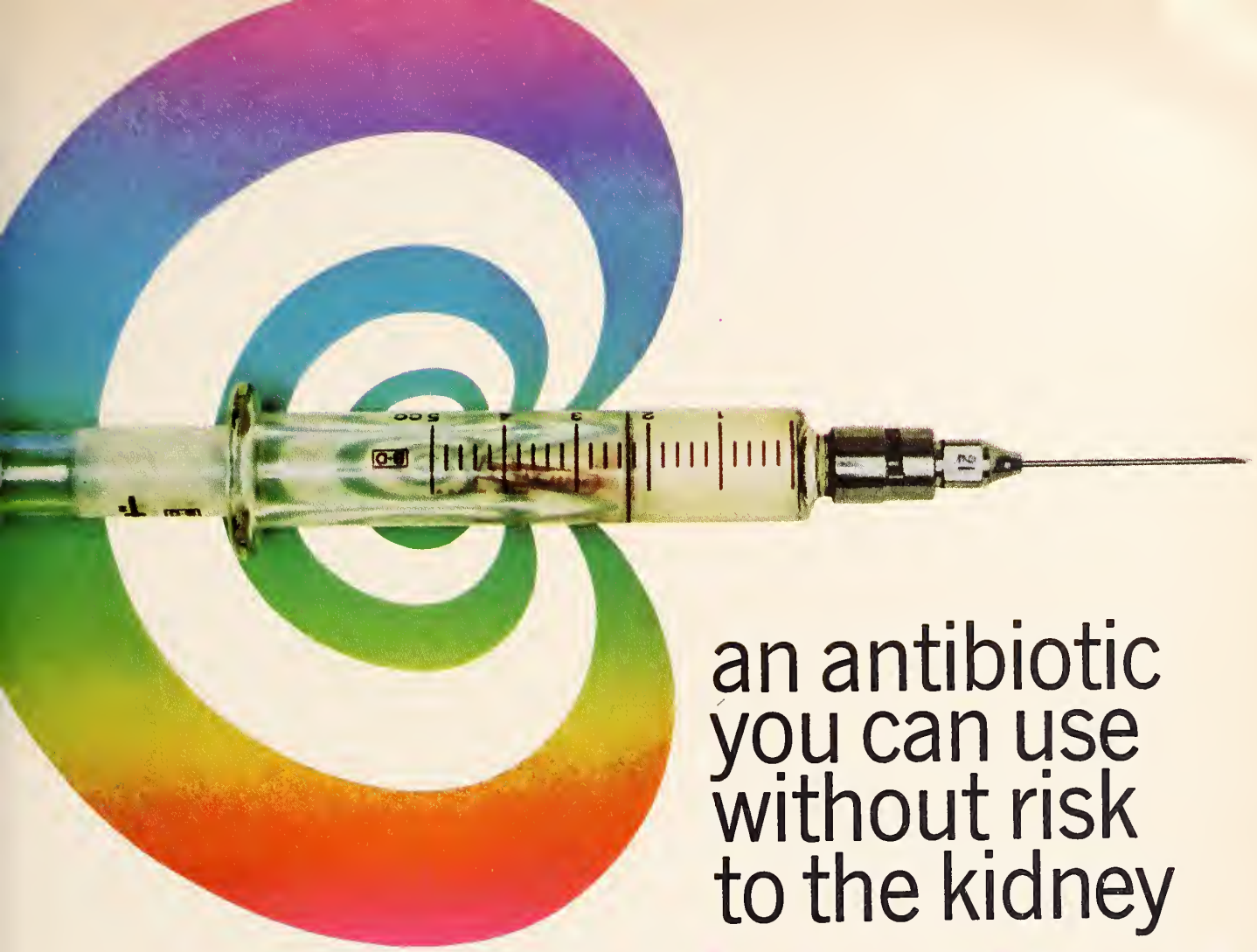
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Indications: Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli, H. influenzae, P. mirabilis, N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci).

Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.

Precautions: Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.

Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.

Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis—150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.

Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles.

A.H.F.S. Category 8:12.16

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201



Indications: For the treatment of trichomoniasis in both male and female patients and the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture.

Contraindications: Evidence of or a history of blood dyscrasia, in patients with active organic disease of the central nervous system, and the first trimester of pregnancy.

Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers; it is not known whether this can be injurious to the newborn.

Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia*, exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weak-

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The effectiveness of Flagyl in *Trichomonas vaginalis* vaginitis has been so constant that use of less effective agents would seem to invite unnecessary failures. ▪ The simplicity, completeness and persistence of cures with Flagyl qualify it as the logical first therapeutic choice in trichomonal infections.

simple Ten-day treatment with Flagyl oral tablets has replaced a multitude of untidy douches, powders, creams and jellies.

complete Flagyl is the only medication available that is able to reach all the crypts, glands and cavities of the female urogenital system as well as reservoirs of reinfection in male trichomonas carriers.

lasting Flagyl eradicates resistant, deep-seated invasions of *Trichomonas vaginalis* and consistently produces cure rates above 90 per cent and often as high as 100 per cent in large series of patients. When the diagnosis is positive, Flagyl is positive.

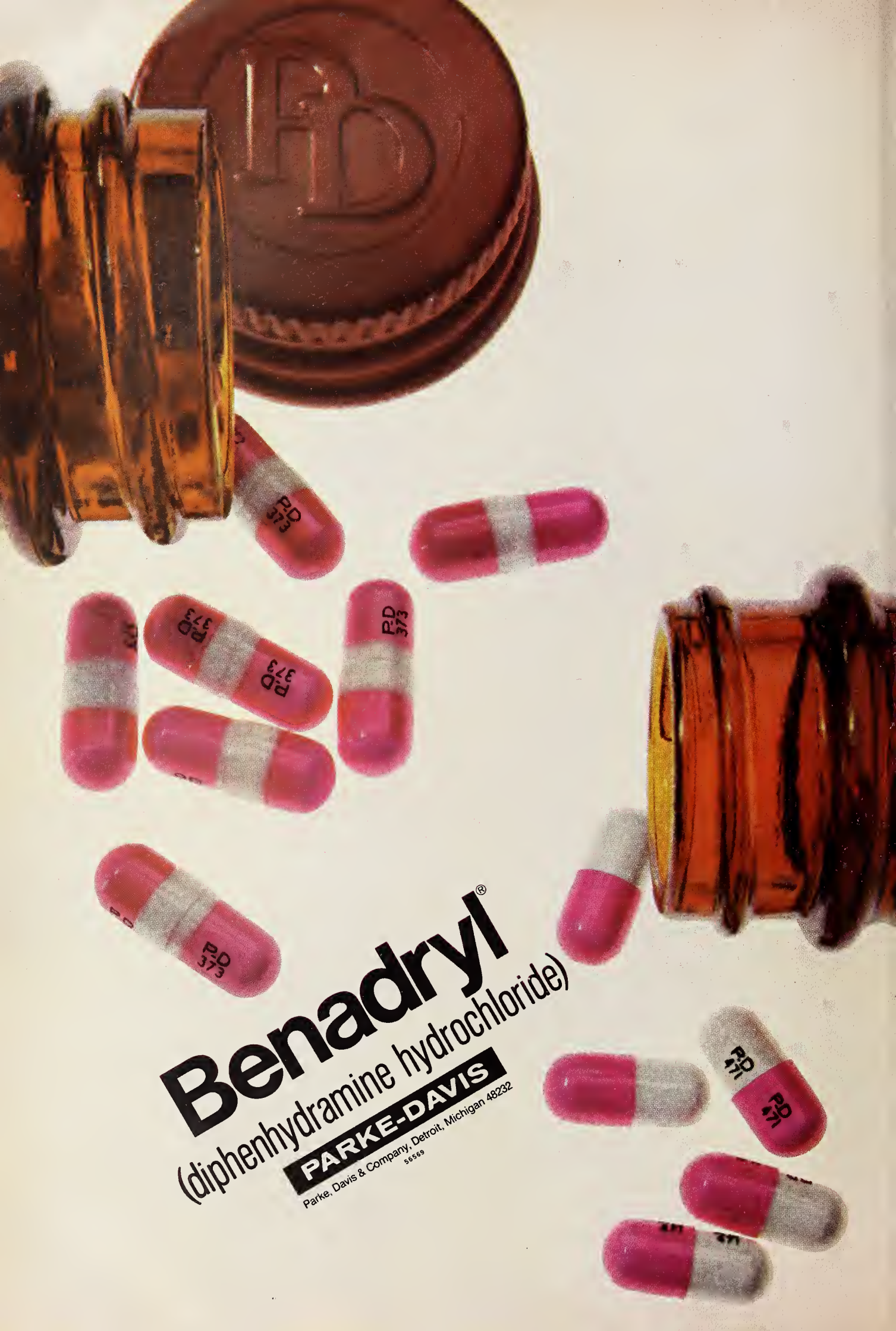
ness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

Dosage and Administration: In the Female. One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used,* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the *oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment.* Do not use the vaginal inserts as the *sole* form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

Dosage Forms: Oral tablets .....250 mg.
Vaginal Inserts ...500 mg.

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County Medical Society Officers Conference

April 12-13, 1969
Airport Holiday Inn
Indianapolis, Indiana

How You Have Been Legislated—Your Role Under Title XIX

DONALD E. WOOD, M.D.
Chairman, Commission on Legislation

What I'm going to do this morning is to recite to you now what happened in your last legislature, as best I can, and those bills that would be of importance to you.

I think the first one would be Senate Bill 33 which compels testimony of witnesses regardless of the constitutional privilege and provides immunity from prosecution for crimes exposed by the testimony. This bill became law.

The next one that would be of some importance to you is the glue sniffing law. This was labeled as a misdemeanor and levies a penalty. This bill was signed into law, and as all of you know, some of the kids today go around sniffing glue and here's a real thing that you can tell them . . . . we've got a law against it.

The next one I think is important provides for a Commission for the Handicapped to develop a plan of services for multiple handicapped people, including the possible construction of a state facility. This bill was passed but it was vetoed by the Governor. This is one of the bills that we supported as a package group that was put in by the State Board of Health in trying to help the handicapped throughout our state.

Senate Bill 52 was like that too. It authorized the State Board of Health to conduct a demonstration project involving the handicapped in order to develop state programs for the care and treatment of multiple handicapped persons. This bill didn't get to the Governor. It died in the committee.

The next one was a bill that required that birth certificates of children born out of wedlock include the birthplace of the mother and father. This bill became law. If you can do that, you're a Houdini. That's like sniffing glue, but nevertheless, it's the law.

Senate Bill 57 amends the Air Pollution Control Act and establishes means to certify automobile air pollution control equipment, permit declaration of air pollution as an emergency and provide a fine of $500 per day for violations. As you know, air pollution has been one of the major concerns of the AMA, the national congress, as well as our own state organization and our state legislature.

The next bill is Senate Bill 81. It goes back to Dr. Rifner's time. This year we finally have provided that all counties, cities and towns must, January 1, 1971, close all open dumps. So, I'm sure that you will know in your own communities now where you stand on that one.

The next one, Senate Bill 89, is a universal bill that has been encouraged by the AMA to be passed in all states. It's the Uniform Anatomical Gift Act which authorizes gifts of all or part of a human body after death for medical and scientific purposes. This bill has been signed into law.

The next one is Senate Bill 118 which eliminates the requirement that the cost of maintenance of mentally ill patients in family boarding homes shall not exceed the cost in a state hospital. This bill also became law. As you know, this takes out the possibility of a family profiting on the illness of some one member of their own family.

Our next one is Senate Bill 201 which permits the State Board of Health to subsidize local health departments. This, I think, is in the nature of sanitary engineers and to provide suitable staffs within the county health organization as is required. This bill we supported so we can have that as one of the pluses in our efforts.

The next one is Senate Bill 215 which makes it unlawful to drive under the influence of any dangerous depressant or stimulant drug in addition to habit-forming drugs as provided under the existing law. This is another one that we supported and this bill became law.

Senate Bill 216 prohibits the issuance of a driver's license to any person determined to be a user of any dangerous, depressant or stimulant drug. This bill also became a law and this bill was actively supported by your commission.

Senate Bill 225 requires the suspension or revocation of a driver's license and registration of any person convicted of possession, use or sale of narcotics or habit-forming drugs. This also became law and we supported this particular bill.

The next one is Senate Bill 348. It revises the 1967 Meat Inspection Law to conform to the federal law and extends the mandatory date for inspection to November 15, 1970. This is one of our bills in conjunction with the State Board of Health that we supported and is another plus for us.

Now the House Bills. The first one was House Bill 1072 which provides for the implementation of Title XIX of the Social Security Act in the state of Indiana by January 1, 1970. This

bill became law and as you know, your state organization did not take any stand for or against it but when we were asked, we did say that we felt that the approach to the problem was to take the minimum approach in view of the experience in many other states throughout the country. To further amplify this, Title XIX encompasses all the present health agencies such as Aid to Dependent Children, the Blind, Old Age and the Disabled. As you know, in our law, we require citizenship and also residency requirements. This would take care of that particular position to make us comply with the federal law. The second one is for children under 21 whose families do not have resources to give health assistance to those individuals under 21. This particular new concept of Title XIX in Indiana will enable us to do something about that. The anticipated cost is $270,000 for the biennium. This is part of, I think, the $14.000.000.000 total health care program for the biennium in the state.

Tomorrow morning at our breakfast the new director of the State Department of Public Welfare, Mr. Sterrett, will be our guest and all questions pertaining to this phase of the problem I'm going to refer to him because he certainly is the authority in that area.

The next one is House Bill 1151. This requires doctors, hospitals, health and welfare departments and superintendents of state institutions to report handicapped persons to the State Board of Health who shall compile and analyze such reports. So, you have one more report to make to the State Board of Health. This became a law.

Then, House Bill 1165, which is the Implied Consent Law in which a person agrees when arrested for driving under the influence of intoxicants to be subjected to a breath test and authorizes the commissioner of the Bureau of Motor Vehicles to suspend his license for a period of not to exceed one year for failure or refusal to submit to a breath analysis. This bill was supported by your organization as directed by the House of Delegates and it became law.

House Bill 1240 provides that the insurance policies issued after the effective date of this act, which is April 1, 1969, shall provide for the payment of services performed by chiropractors, osteopaths and optometrists. This bill became law. As late as the day before the Governor signed the bill, he told me he would not sign it, so this you can count as a loss in our program.

House Bill 1261 permits a person under 21 who has, suspects, or has been exposed to any venereal disease, authority to give his or her consent for care and treatment of the disease. This bill became law. They can now go to a doctor and assume responsibility for their own care.

House Bill 1338, an association bill, declared that blood and blood products, as well as tissues, are a medical service rather than a sale. This died in the Judiciary Aid Committee in the Senate. They had the feeling that we were trying to legislate a lack of responsibility and we could not get the true importance of this bill across to that particular committee, so we lost. That's another minus.

House Bill 1344, another one of our bills, created a division of medical care and treatment in the Department of Correction and placed an M.D. in charge. This died in the House committee. Again, we were unable to get our point across and this is another negative against us.

House Bill 1375, a bill to provide for certification of qualified psychologists, became a law effective July 1, 1969. We supported this bill and they came to our organization long before the bill was written. We all got together and made it, what we felt, was a good bill.

The next one is House Bill 1468 which amended the Medical Practice Act by deleting the limitation of a charge of $25 to take the examination and replacing it with a fee not to exceed $100. This bill passed and became law. This enabled the state board to accept the FLEX examination rather than the written examination as has been customary in the past. I'm sure that this is going to be a good bill that will eliminate a lot of problems, not only at the university level, but certainly in some of our Departments of Correction, for example, where we can now get people to come into the state and not have to take the examination. I think this is one of the very good pluses.

The next one is House Bill 1583. This authorizes the podiatrist to administer and prescribe certain drugs. It does, however, prohibit the use of anti-inflammatory, systemic drugs, such as cortisone, etc.. This passed both houses and became law. With the direction of the House of Delegates, we did oppose this bill. The only thing it allows them to do is to locally treat the feet to try to prevent infection by capital application but they cannot use the steroid.

The next one is for the licensing of physical therapy assistants. This died in the Senate committee. We did oppose it on the basis that they had so many people in the physical therapy schools now they didn't have enough professors.

The next one is 1756. It created an Indiana Medical Education Authority of eleven individuals and authorized it to adopt a program to expand medical training resources, increase the number of medical graduates, to acquire a site and hire an architect for the construction of a school. This finally passed both houses but it was vetoed by the Governor.

The next one, House Bill 1775, authorizes the state Mental Health Department to establish a network of local community treatment centers for the treatment of drug abusers and this bill was also signed into law.

House Bill 1870 makes it unlawful for a person not admitted into the practice of medicine to represent himself as a physician. This bill passed

the House but died in the Senate Committee on Courts and Criminal Code. We were in support of this.

The next one is House Bill 2000 which prohibits children from attending school more than 30 days beyond enrollment without furnishing written proof of immunization and directs school authorities to file such proof with the State Board of Health within 60 days of enrollment. This bill was signed into law. As you know, these kids who have already been in school and come into your office and get a vaccination have created a lot of problems, so the State Board of Health has finally got this worked out so that this situation will no longer exist. We supported that bill.

The next one authorizes the Board of Health to prescribe a form to use as written proof of TB tests for school children and directs that no child shall attend school for more than 30 days without written proof of such a test. This bill was also signed into law and we supported that.

Now, I'd like to say that there were many bills to create new medical schools and take over all the Marion County properties of Purdue and Indiana University and convert them into the University of Indianapolis. None of these bills were successful in becoming law, so as you can see, we had some 70 bills that were directly important to the practicing physician in this state. I've only given you a handful of the more important ones, but here again, I think you see what the state organization is doing for you in the practice of medicine.

Now I want to get to the Washington scene. I think it's important that you have some concept about what's going on nationally and as you know, I think that the AMA, following the last election, has a little better report on the bills and in the White House than it did during the previous administration, and for this reason, I think that you can anticipate that the AMA will have a forward, ongoing program. We will try not to be reactionary or put in a position of having to be reactionary, but we are hopeful that we can produce some legislation that will be helpful to the practicing physician. I also would like to take this time to reiterate that if it becomes necessary to become reactionary on any legislation, we certainly will do that, but we want to change our approach. Now, to review a few of the federal laws that are under consideration and some that I think will be of importance to you, I will recite a few of those for you. The HR 1, the first bill put in the House, has to do with the Uniform Service Academy of Health Sciences which establishes a Uniform Service Academy of Health in the District of Columbia area and provides for a 15 man Board of Regents to govern the academy. The AMA position on this has always been one of opposition. We feel that (1) the same amount of money given to already established medical schools would produce far more doctors than the establishment of a single medical school for armed forces personnel.

The next one was the Health Insurance Benefit Act of 1969 which is under discussion. This bill would amend the Insurance Revenue Code to provide a new system of income tax credits for the taxpayers. This, of course, is AMA policy. Congressman Fulton has already drafted a bill and we've been in conference with him in attempting to get the bill drafted so that it will embody the attitudes and ideas of the AMA of giving credits for the purchase of health insurance.

Now, HR 8 is the unofficial Organ Transplantation and Technological Development Act of 1968 which authorizes the development of separate centers for separate organs. We opposed this on the basis of the establishment of a kidney institute, a lung institute, a liver institute—we feel that the benefits to the kidney treatment patients, regardless of age, would be an unwarranted expansion of the Medicare program.

The next one was a reasonable allowance for physicians' services under part B of Medicare. This bill amends the Medicare program to pay for physicians' services on the basis of "reasonable allowance" rather than the "reasonable charge" basis under the present law. The secretary of HEW was determined the allowance was different in geographical areas. This bill, as you can see, disregards the physician's customary charge as a proper basis of payment and would make the basis of payment the average payment made by a nonprofit, medical, prepayment organization such as Blue Cross or Blue Shield. We oppose that bill totally.

Then, there were many bills on drugs. In general, we support the drugs in government-sponsored programs when furnished in relation to financial needs of the patient and providing there be no restriction on the physician's free choice of drugs other than in his own professional judgment. I think that you would all agree that as long as that general policy is followed that that would be within your own ideas.

Now I mentioned before that we were going to have a forward program. I'd like to mention to you a few of the bills that we are in the process of sending to your Board of Trustees and then to the House of Delegates for possible implementation in an attempt to help again the private practitioner. I want to point out here again some of the things that the AMA is doing for you, the private practitioner in medicine, regardless of where you practice.

This first one would be a bill to amend the anti-trust laws to provide that the refusal of non-profit blood banks in the hospitals and physicians that obtain blood and blood plasma from other blood banks shall not be deemed to be acts in restraint of trade. You see, we lost this bill at the local level, but there are many implications that are involved in this in which you, the physician, could actually be sued for improper administration of blood that

might have hepatitis, for example.

Next are bills to create a national advisory commission to study devices; a bill to eliminate the recertification requirements for general inpatient hospital services under title XVIII and then remove limitations of psychiatric care under titles XVIII and XIX; a bill to permit direct billing of all title XIX recipients; a bill to enable the beneficiaries under title XIX in Puerto Rico and the Virgin Islands to have a free choice of providers and services, (they haven't that now); a bill to provide the option to receive hospital care and facilities other than in VA hospitals; a bill to amend the Military Selective Service Act of 1967 as it pertains to selective service call to physicians and to provide for allocation of health personnel among the armed forces, governments and civilians.

Then the next one would be the Occupational Safety Health Act of 1969 which has to do with hazardous agents. We here in Indiana have asked some legislation in that area but we have recommended opposition to the creation and enforcement of mandatory national standards for occupational safety and health, and we have urged instead that the setting of the standards should remain within the states and that the federal government can best serve the purpose of this bill by assisting them in upgrading and enforcing their own occupational safety and health program.

Now, the next one, I think, is a bill that you are all familiar with. It's the new modification of the Hill-Burton proposal. The Hill-Burton, as you know, was originally a hospital construction program but today, I think, much is being said of the needs of modernization instead of construction and I think that perhaps there has been a change of attitude that the emphasis now under Hill-Burton has impetus of modernization. The states have been spending most of their money for rehabilitation, for modernization, etc. of existing facilities primarily in urban areas and there has been less emphasis on rural areas than there has been in the past. I think that Secretary Finch has proposed that the grant system for hospital construction be ended and replaced by a loan guaranteed program. If you read some testimonies before the house committee, there was some comment by the press that the AMA was in opposition to Secretary Finch because he was supporting the loan and we had been supporting the grant position. Well, this is not true. We do not take any position on eliminating the grant factors or eliminating the loan factors. We thought perhaps in due time that probably the grant phase could be phased out but the AMA, as I said, has supported a loan guaranteed program and I think that you would agree that in many instances, they are preferred over the direct grants. In loan guaranteed programs, the government acts as a guarantor and subsidizes part of the interest payment that encourages the use of the program. The federal expenditure is really a minimal one so the AMA has given testimony to this fact and has supported it. I think that we are in accord with Secretary Finch's idea. HR 1159 which is the Assistant Secretary of Defense for Health Affairs, we have not taken any action on other than to say that we would support this but again we feel that through Secretary Laird, we would have a good ear to discuss this problem, and we feel that we ought to have time to review his own organization and see whether this would really be a good idea from his point of view.

As you know, Senate Bill 16 is the Adult Protection Act of 1969, better known as Preventicare. This bill establishes a multiple screening program to provide a health evaluation of all individuals, 50 years or older, who wish to participate in the program. The bill provides for the establishment and operation of regional community health protection centers and for the training of personnel to operate such centers. A provision is also made for the conduct of research related to such centers and their operation. We have taken a position of opposition at this time until such time as further studies are completed concerning the use, the cost and the reliability of multiphasic screening. In other words, we don't think there's been enough real study in this area to come up with a real position.

Now, I want to talk about political action, IMPAC. With the new billing system for IMPAC membership, I can tell you that the physician membership has more than doubled. I can say reservedly that not just a few have had their shoulder to the wheel, but many. This is the way it should be. Your membership of the board has been changed by action of the Board of Trustees so that now each district in the state is represented on that board and the actions of that board are a composite action totally. You can know that this action is a bipartisan action as was in this last election, your board and IMPAC also supports AMPAC, and I think that our action this past year will be interesting to you at the coming AMPAC workshop in Washington in May. Indiana won the first place award for the greatest ratio of members to potential. They were second place in the number of dollars per petition per state and they were third in the total contribution. I think this speaks well for Indiana.

Now, you want to know what else we get back from AMPAC, if we support AMPAC? I can tell you that over the years that we have participated with this, we have received more back from AMPAC in dollars, hard dollars for political contribution, than we have donated. Thank you very much.

(Dr. John S. Farquhar, chairman of the Commission on Emergency Medical Services, spoke briefly on "Is There an Emergency?" His remarks were printed in the May issue of *The Journal.*)

Who Speaks for Medicine in Emergency Medical Services?

FREDERIC L. SCHOEN, M.D.

Until recently, the Indiana State Medical Association was represented in studies and planning of emergency medical services by a board committee and a few representatives on the Governor's Commission on Emergency Medical Services. This situation was altered by the 1968 ISMA House of Delegates with the formation of a Commission on Emergency Medical Services. This commission was deemed necessary because of the tremendous flood of emergency medical care requests, some of convenience and some true emergencies with public criticism of the lack of care of both categories. It is imperative that medical judgment guide the hospital administrator, nurse, health planner, politician, and patient in the provision and use of these services. Those who seek to improve emergency services should be helped; those who seek to interfere with these services should be quietly controlled.

Few physicians understand the concept of community medicine. It holds more appeal for those in large medical centers than for busy practitioners. But it is necessary that we accept its validity and apply it for the betterment of doctors and patients alike. Nothing emphasizes the needs and demands of the community like the patient population seen in the emergency room. Consequently, the effort to upgrade emergency care and to evolve an efficient system must include an evaluation of many factors outside of the clinic, hospital and emergency room. It is from a total experience of providing good effective care to the flood of patients at night and on weekends that we can develop the expert methods to save the few who present us with major emergencies, such as traffic injuries.

It is often said that two out of five traffic deaths could be prevented by good medical care. If so, the effort must begin at the scene of the injury. There is little truly effective first aid. In the 3,000 total accident deaths in Indiana each year, few are killed outright; many die in need of immediate care. To add up the number of those trained in first aid, we begin immediately to work with the American Red Cross and the State Board of Health. There are, in both organizations, personalities and attitudes which conflict with the medical profession. Our motive is to increase the availability of *skilled first aid*. It will not be achieved by organizational infighting. The need for political effectiveness and diplomacy is enormous. It has been suggested that every driver capable of inflicting injury with his car should have basic first aid as part of a driver training. This is a major goal toward which we should help the Red Cross and other health organizations.

Rescue and transportation from the scene is the task of various ambulance services. This vital field is easily surveyed; it is chaos, with equipment varying in type and quality. Little of it is well designed and all of it is expensive. Operations vary from haphazard to sophisticated. Manpower and expense are the main problems.

The public dramatizes and mistakes speed for life-saving ability and it requires professional judgment to know better. Physicians need not be encumbered with problems of registry, licensure or subsidy. We are concerned only with standards. There is the opinion that an effort to raise standards or accredit ambulance services would force many morticians, who are now providing service, out of business. Certainly, hard-pressed ambulance operators will oppose higher standards by the threat of withdrawal from this type of service. But will they really do it? Would community opinion allow them to leave without replacement? I doubt it. Here is the place for organized medicine to stand up for excellence. Good care is the goal of our professional life; providing it is the key to our future security. We need to take a stronger stand on quality of ambulance service *now!*

The whole area of coordination and communication is beyond the traditional limits of our practice and understanding. We recognize the basic facts of the telephone system, however, improvements, such as the 911 System are obtained only by planning emergency centers where such calls can be received and translated into an effective response.

In our communities, only law enforcement agencies have full-time manpower and professional skills to man an operation center. Police, fire, ambulance and rescue units require coordinated dispatching. Our present city limits and county boundaries are formidable barriers and often prevent area-wide operations. We physicians will not enjoy the task of keeping patient care above political rivalries. Little has been done to resolve operational and jurisdictional disputes between city police, sheriffs and state police. But we must see that good emergency care comes first. Most of us are aware that Nebraska has planned an exemplary Emergency Communications Network. We need to copy its good points and adopt them to our state's needs.

In recent years the operation of the emergency room has become a headache for hospital administrator and medical staff alike. As more public and professional scrutiny is directed to this busy area, we can expect changing accreditation requirements. These are the perennial excuses for increasing hospital control of practice, but they are also necessary to bring the performance of many hospitals into the 20th Century.

These facts, plainly stated, will give our association and its leaders cogent reasons for doubling the present efforts in the field of emergency medical services. Failure to assume the position of leadership and the voice of authority can result in grievous loss for our profession.

Emergency Medical Services

CARL D. MARTZ, M.D.
Chairman, Governor's Advisory Committee on Emergency Medical Services

Officers of local medical societies will constitute the working force to implement the program of emergency medical services for the state of Indiana, which will soon be presented in its final form. Of the 57 recommendations which have been the product of the study task forces over the past years, one has to do with highway signs which has been generously discussed at this meeting. Other recommendations are also important.

Emergency notification by the 911 number is definitely desirable but emergency communications in Indiana has to do with more than Bell Telephone and the General Telephone Company for there are 87 other small companies operating in our state.

Before long you will hear from resource personnel throughout the state that will implement the challenge that has come to us to provide an emergency facility within 15 miles or 30 minutes of every citizen in the state of Indiana. Doctors represent resource personnel that will be the most important, but I must hasten to say that such planning includes more than medical personnel.

Only one-half of the membership of the advisory committee for the state planning were doctors and I believe this is as it should be because in providing emergency services there are many important considerations: the communications people, the highway people, the ambulance people, the police and fire departments, nurses, Red Cross instructors, and highly trained people for the development of data systems and proper data retrieval.

In the task forces which were sent out by the overall committee, doctors constituted only 25% of the membership. This, too, was as it should be because the chain of events constituting emergency medical services has many vital links.

We just finished an Ambulance Institute with an attendance of 150 men assembled at the General Hospital and the State Board of Health training for emergency service throughout the state of Indiana. This is the fourth such group that we have had in six years, with a total of more than 500 men. They represent one of the most interested and active groups I have ever met. Their one desire is to help the doctors in the care of their patients at the time of emergency.

Now and then, I find a doctor who says he has no interest or concern for the emergency service. I find this hard to understand and difficult to accept. Our public is interested. The hospitals are interested. When the chips were down, I found that most doctors in general and special divisions are interested and active.

The Committee on Trauma of the American College of Surgeons and the State Board of Health welcome this interest and promise we will move in accord and in close relationship to the state medical association.

We are all concerned in Plan 4-4-11 of the National Highway Act and must continue in close cooperation for the achievement of that type of emergency medical services for which Indiana can be proud.

How Important Is Education—Panel Discussion

LOWELL H. STEEN, M.D.
GEORGE T. LUKEMEYER, M.D.
JACK W. HICKMAN, M.D.

DR. STEEN: I have been active in the Indiana State Medical Association for some 10 years now. I have had the opportunity to attend two county society officer's meetings—the one last year and this. So far, this one has been a successful meeting and I hope the remainder of the program will be equally successful. The one last year was outstanding and I should like to suggest to you that perhaps we should think about something to which the president alluded earlier. We should consider an interim meeting of the House of Delegates. I think perhaps there is some merit in having two meetings of the house per year. It would provide better communication, it would broaden the base of decision-making, it would give us more time to think on the problems that have occurred in the state and lastly there would be less time lapsed between decision making and implementation. I hope at a later date to discuss this matter with the Board of Trustees and would hope that ultimately a resolution is submitted to the house this fall to provide a basis for discussion about the potential of two meetings of the house a year.

Continuing medical education! One of the most critical issues facing our profession today is the need for continuing medical education. A mechanism by which the physician in a busy practice, and overworked, can be stimulated to learn effectively and continue to learn effectively. There are now pressures from the government. There are pressures on us from the specialty groups. There are pressures from the new American Board of Family Practice to continue to learn. There is pressure to upgrade our abilities and our technical skills. The national board has recently considered the potential of relicensing and recertification. Oregon recently raised their dues to be used to supplement an expansive program of continuing medical education with the requirement that all physicians must participate each year in a given number of hours of education to retain their membership in good standing with the Oregon Society. It's a coming thing, gentlemen, and I fear that we must prepare for the fact before it is an order. Medical knowledge increases in geometric proportion and the key to the problem is stimulating the physician to want to learn. I think it is our duty as officers of county societies to make learning an interesting process. I think it's our duty to make learning and the facili-

nes for learning readily available. I think it's our duty to make it relatively painless and I think it's our duty, if possible, to even make it fun to learn.

The county society has long abrogated its responsibility for continuing medical education to the medical staff. The staff is not equipped to take over this function because it is a mandatory function, not an optional fun thing. It is imperative that we restructure the entire situation as county societies so as to assume the role of policy in education for practicing physicians. I think it is time that we experiment with new techniques. I think it is time for innovation in the learning process. I think we should make adequate moves that the 12 or 13 directors of medical education in the state of Indiana are used in the area where they have great expertise—continuing education. I have had communications from several of these gentlemen volunteering their services in this program to help to structure the program so that physicians will participate. We have had the cooperation of the Indiana University School of Medicine and they have reaffirmed their willingness to participate in this program, to further leadership and to provide whatever skills they have to help make these new programs work effectively.

We must make use of the governors of the College of Physicians and the College of Surgeons. Because most of our physicians in Indiana are general practitioners, we should make use of the skills of the Academy of General Practice and the new American Board of Family Practice. I have discussed this subject with many of the individuals I have mentioned and with our Board of Trustees. They are probably so tired of hearing about continuing medical education that one of these days they'll either expel me or crucify me upside-down, yet I think this is an important subject and we intend to make this a primary program of this organization. Next year, when I am your new president, I hope to give this further thrust. I don't want to detract from our present president who is vitally interested in this subject and who has urged me on with it and placed the burr under the seat of the trustees to accept innovations in a new system of continuing medical education.

I would hope that at the conclusion of this meeting that every county society officer who is here will go back to his respective county and charge his Committee on Continuing Medical Education or his Committee on Medical Education to make this a prime program. In the counties where no Committee on Medical Education exists, I would hope that one would be established almost immediately and I would likewise urge the members of the Board of Trustees to work in a similar fashion in their areas.

I would hope that the president of every county society in this state would make medical education one of his prime programs, and it is my hope that these committees will very soon meet with our Commission on Medical Education and with the Section on Directors of Medical Education to try to develop programs that will have interest and that will stimulate physicians to want to learn. The primary hang-up in continuing medical education is the physician's attitude toward learning! This is really the key to continuing medical education and thought should be given to possible new ways of stimulating, or encouraging, or requiring physicians to learn, not only in the sanctity of their libraries or their offices or their homes.

It is to some of these new and more "way out" techniques of education that I want to speak today and then my distinguished colleagues, the associate and assistant deans of the school of medicine, Deans Lukemeyer and Hickman, will speak on a subject of their own choosing relating to the university role in continuing education and the university facilities for implementing these programs.

First, the use of the medical audit as it now exists and techniques for pointing out areas in which educational endeavor might be directed. A reservoir of information exists in virtually every hospital relating to the practices and the morbidity and the mortality in that institution. Unless this is to become a futile exercise, in which data are stored away in the archives of the hospital to be forgotten forever, we must make use of this information. I would say to you that where areas of excessive morbidity or mortality that exceeds the norm of morbidity and mortality exist, this fact can point out areas in which we can concentrate continuing medical education. An example that I recently heard at the Congress of Medical Education is a community in Kentucky where it was noted from the statistics of the State Board of Health that there was a very high mortality incidence in the perinatal period. Resulting from this knowledge, the Academy of Pediatrics structured a series of conferences relative to this particular period of life. These conferences were well attended and within a six month period the mortality statistics at the State Board of Health had shown dramatic improvement. This is an indicator of how valuable study of existing data can be in structuring continuing medical education.

For many years the University of Chicago has pioneered in home study courses and virtually every field from archeology to oceanography to advanced international law to freshman biology is covered. To the best of my knowledge, no medical organization to date has developed or has worked with home study courses save the American Heart Association who, to the best of my knowledge, has one very excellent course in electrocardiography that can be taken as a home study course. In conjunction with the university, this state organization and the county organizations throughout the state might develop home study courses to increase phy-

sician effectiveness.

I have frequently spoken about dial access tapes. This is a technique in which a telephone number is provided by the medical organization on which a two to five minute tape concerning a given topic is available at any hour of the day or night similar to the number that can be dialed in certain cities to obtain a daily report of the weather. Several numbers might be employed where multiple topics are available. These tapes should be changed every few days so this does not become a boring and sterile exercise. This was tried by a drug commission in Chicago a few years ago and was quite successful. This is another technique that would permit a physician and a surgeon too, to acquire some knowledge or a new concept on a given subject and this is only one of many techniques that might be used.

We should experiment with computer assisted education. This is now a big adventure in universities. This technique is not readily adaptable to small groups of individuals but it might be used at the state medical association or at a district meeting. There is a new hospital computer network that is envisioned in the state of Indiana, and at some future date this might be available in every hospital throughout the state or it might be extended to your office or to your home.

In the traditional program of instruction, we must experiment with new techniques such as the one we plan to use tomorrow, the breakfast roundtable. We might have luncheon critiques or we might have simple coffees of a half hour duration in which eight or 10 people can, using an old Indiana term, "borass" on a given subject. These sessions should be informal with much audience participation. I think it should be stressed that the essential necessity for audience participation is one of the keys to making learning an interesting process. To sit in an audience such as you're sitting in today becomes a very boring experience particularly after a big lunch and moreover, after several martinis, it's almost impossible to gain anyone's attention for long. Yet, if there is audience participation and if there is an interchange of ideas, the educational process can be interesting and there is no dearth of talent. Every county in this state has available people who can participate! One can invite experts from adjacent communities. One can invite people from the university school of medicine who are delighted to participate in these programs.

Live two-way television conferences, and I stress the word "live." I've talked to Dr. Lukemeyer about the failure of the current television monitors that have been placed throughout the state by the university school of medicine with the funds allocated by the 1967 biennium of the legislature. The failure of the monitors to be used adequately is the fact that it is a passive exercise. It is a form of one-way communication. The student assumes a passive role and students do not like to be passive. They like to be active and if lecture rooms were designed so the audience can participate, this would be an infinitely more interesting exercise and would be more widely participated in.

Set assessment programs have gained widespread recognition recently. I would like to see the state organization in conjunction with the county medical society develop a series of self-assessment examinations, not only for the generalists, but perhaps starting with the generalists, to be structured after the examination given a year or so ago by the College of Physicians. In talking to representatives of the GP group, I find that the new Board of Family Practice has structured a similar self-assessment examination except it's going to be called a board examination. It's definitely more sophisticated than the examination developed by the College of Physicians and sounds like a lot more fun. If I may outline briefly my thoughts about this, I would like to see an examination on which there is no passing grade for we must do away with that traditional concept of the passing grade in an examination. We must do away with the traditional concept in which the exam may affect your licensing or relicensing. We must do away with the traditional concepts that this might do away with one or several of your staff privileges. *This exam is for YOUR OWN benefit,* and it is to point out to you the areas of your deficiency. I am sure that every man in this room and every woman in this room knows his or her own deficiency, but to have it pointed out graphically is of some value in clarifying the real need to get in and dig at this. Moreover, this has the ancillary benefit of permitting you to receive from the experts who have written the questions a tremendous document indicating what you have answered wrong and what the correct answer is with cross references to the literature where, at your leisure, you can read, study and upgrade your medical knowledge. I hope that the state medical thru the Commission on Medical Education will move forward and experiment with some of these techniques and many others of which I have not spoken. I would hope that my own enthusiasm for this field of continuing medical education is so contagious that every person in this room will go home and immediately try to plan for new and more active programs on the county level, structured according to the needs and the variability of his own individual county. The techniques will, per force, vary from county to county, but I think, the important step is to take recognition that the county society *does* have a role in this area and that our traditional concept of providing educational material must be largely discarded. I would like to leave a last thought with you, that INNOVATION is the order of the day.

DR. LUKEMEYER: Dr. Corcoran, Dr. Steen, I am pleased to participate in this Conference for County Medical Society Officers. Dr. Steen's opening remarks have set the tenor for today's meeting.

Dr. Steen asked and answered the question of "how important is continuing self-education for physicians." He obviously endorses continuing self-education for all physicians.

Practicing physicians do not suffer from a lack of available medical educational resources. They are the victims of "information overload." There are numerous textbooks and many medical journals to be read. Scientific meetings are sponsored by community hospital staffs, medical societies and various specialty organizations at the local, state and national level. A wide variety of formal postgraduate courses are available throughout the state and nation. Audio-tapes and single concept films are used extensively. Another important informal educational device is the "corridor conference." It would be an error to overlook the efforts of detailmen representing various pharmaceutical companies. The pharmaceutical companies also send out a variety of publications to physicians. We recognize that lay periodicals contain medical information with which we must be familiar.

The physician is faced with the task of selecting what is really important. He seeks educational material in a form, at "a time, and at a place" which is convenient for him. There is unnecessary duplication of effort and a significant lack of coordination in the utilization of our educational resources and facilities both on a statewide and nationwide basis. Educational programs should be more effectively coordinated in the future.

During his opening remarks Dr. Steen commented on the topic of motivation. It is very difficult to know how best to motivate physicians for continuing self-education. We must recognize that there are individual preferences which determine what methods the physicians will use to carry on self-educational programs. Some will wish to read selected articles and reviews in the solitude of their library. Others will be more inclined to listen to audio-tapes. Still others will prefer to use single concept films or video-tapes. Many physicians pointed out that the tremendous demands for patient care services interefered with their ability to participate in educational programs.

At the medical school, we have a basic commitment to undergraduate medical education. The faculty is involved in research at an appropriate level and provides some patient care. Our faculty supervises the graduate medical education of interns, residents and fellows. Faculty participation in relevant continuing medical education programs has increased significantly.

"The Indiana Program" emphasizes coordination of undergraduate medical education, graduate medical education and continuing self-education. Medical students are a potent catalyst for continuing self-education.

Dr. Steen has indicated some of the shortcomings of a video-tape network and has requested that I make some comments regarding our statewide television program.

The Indiana Higher Education Tele-Communication Network is being developed by the four state universities and inter-connects the universities and their regional campuses. The 1967 state legislature made funds available to the medical school to develop the intra-city television interconnections.

The following communities can expect "live" instructional television: Lake County, South Bend, Fort Wayne, Lafayette, Kokomo, Muncie, Indianapolis, Terre Haute, Bloomington and Evansville.

We will share the IHETS network with the four state universities and their regional campuses. Obviously, there will be scheduling problems. The medical school would like to have free access to two-way television and audio inter-connection with community hospitals. Ideally, a television camera and crew could be taken to the bedside of a patient and a discussion could then be held between the physicians in the community hospital and the faculty members at the medical school. This is a very expensive use of television and presents almost insurmountable scheduling problems.

As the medical school waited for the development of the live television network, it elected to institute a video-tape network. Color video-tape recorders and monitors were placed in 34 hospitals in 11 communities in Indiana. Video-tapes are available from a variety of sources. The Indiana University School of Medicine has attempted to circulate educational video-tapes which were leased from the University of California. Meanwhile we are developing our production capability so that we may soon circulate video-tapes which have been made on our own campus.

The community hospitals with the video-tape recorders and color compatible monitors have been asked to determine whether scheduled or non-scheduled viewing is best for their staff. The local hospital staffs must decide whether they are going to prefer large or small group viewing. The intra-hospital distribution system design is the responsibility of each of the local hospitals.

The medical school is encouraged with the initial development of the television and video-tape network. We do not know precisely how long it will take to complete the system.

Unfortunately, there is not enough time to describe in detail the medical school's efforts to implement a "medical communication network." The medical communication network involves the movement of people, a teletype network, a voice and data network and the television system. Many of you are familiar with the teletype system which makes the

services of our medical school library available to physicians in 150 communities throughout Indiana. Some of you are knowledgeable about the joint clinics conducted in three cities in Indiana. Visiting faculty programs are regularly scheduled in five cities in Indiana. Many faculty members present scientific programs at medical society and hospital staff meetings. This is a big commitment. It requires a lot of time. The school of medicine is eager to participate in this statewide program of continuing medical education. We hope to see the development of multiple, sophisticated teaching and learning centers throughout the state of Indiana. You can be proud of the efforts that are going on in Indiana cities. Exciting educational programs are being implemented in South Bend, Evansville, Fort Wayne, Bloomington, Indianapolis and other communities.

DR. HICKMAN: The first word on my sheet of notes is motivation. The other two speakers have mentioned it and you will hear it from me more than once, because it is so important in any such discussion. I believe this is the first time that I have spoken on this topic, at a meeting that was not proposed by a school of medicine. I think that the topic "We need more continuing medical education" practically always comes from a school of medicine. Those of us in this room know that the people who need the educating are outside this little room, of course.

A perfect example of good motivation toward continuing education was given by Dr. Steen. That was the high prenatal mortality rate down in Kentucky. When the patients are getting sick and are not doing well, it becomes very clear that there is a reason for doing something differently. I would predict that was why they had such beautiful success down there. Just turning out new information is not enough. We've tried the usual educational methods. Dr. Lukemeyer has gone through these. Every year we put out a beautiful outline of 30 to 35 postgraduate courses. The school of medicine will continue to do that. Roughly 2/3 or probably 80% of these courses will be aimed toward the general practitioner.

I had my "all purpose" slide that I had planned to show because I can use it with any topic. It has one line coming down and one line going up. The one along the bottom is 1900, 1930, 1960, 1990; so it's going to be good for a while. I had planned to show it today because it illustrates that the number of postgraduate courses aimed to the general practitioner since 1900 has increased sharply. Line B shows the number of general practitioners in the United States decreasing equally sharply. Soon we would have one man running his tail off from course to course and he just won't be able to get to all of them. I don't believe that either, but it looks good on the slide. I don't want to believe it.

We ran a survey concerned not only with what methods physicians were using for continuing medical education, but what they would like in the future. Its results checked very closely with a pretend survey that I did a couple of years ago. My guess was that physicians would rank in order of importance methods used in their continuing medical education and that first would be conversations with colleagues. The second might be texts. Third would be journals and fourth would be formal courses. Our survey showed journals as the most frequently used method. We came out with something like 99% of all practicing physicians using medical journals. Second, however, was conversations with colleagues. Texts ranked third and, of course, formal courses ranked fourth. Continuing medical education, to be successful, will require various methods. I think, pretty much as Dr. Steen has mentioned, just putting out more courses isn't enough. Just increasing the television network is not the answer, alone, nor is more journals. It's going to take a combination of things.

We must remember that we're dealing with busy practitioners. On our list of factors that hindered physicians participation was "programs too distant, time not satisfactory, and interferes with time with patients." Just what you would expect. "Not suited to needs," we offered as a possibility. It was ranked low. "No desire to attend" was not mentioned frequently.

In the future all of the various methods were ranked as preferred methods. Formal courses were appreciated. Television increase was mentioned. I think two interesting points here, two factors that were rated very high, was that physicians would appreciate teaching consultants to their hospital and also increased hospital staff conferences. They were not requesting an increased number of staff conferences but using medical education through these staff conferences. These to me mean that the practicing physician is very much interested if you can only make it easier for him to attend . . . if he isn't necessarily having to come to Indianapolis to attend all the conferences.

You have to believe in the accuracy of the information you're getting at a course or in a journal or in a book but that's only one part of it. It also must be current. This is one of the major failings of textbooks, obviously. The information also has to be pertinent. There's little sense in giving all the current, factual information on the Balkan nephropathy in one of our courses. We just don't run into that condition every day. Information should be handy, I think, for the practitioner to get. This factor increases the role of the community hospital. I should think that we should develop as painless a method of learning as possible. What organized medicine's role in this would be, I'm not sure. Cooperative ventures that we have with the school of medicine, and with the professional societies of all specialties and general practice could be valuable. In sum-

ming up I don't have the answer to any of this. I think we're going to need a variety of methods in the future. I would predict that any role that the district, county and state medical organization can play will be welcomed and will be of great value. Thank you.

Is Today Tomorrow—Or is Tomorrow Yesterday?

G. O. LARSON, M.D.
Chairman, Commission on Future Planning

No matter how you attempt to translate this title, there is a certain amount of truth in the title whether you read it backward or forward. The whole idea, I believe, is that in considering the future of medicine and organized medicine, we must contemplate the present and the future in relation to the past. Someone has been quoted as saying "Coming events cast their shadows before." Another quotable quote is "What's past is prologue," so that my comments today will, of necessity, relate to present events and past events as a prologue to what I feel is to come for the people of this country and organized medicine in general.

There is no question whatsoever that we are living in times which are indeed troubled and full of uncertainty. Violence and crime in the cities are revealed in practically every column of our daily newspapers and are echoed throughout the world through television and radio, via satellite. There are protests and demonstrations which reach beyond the limits of temperance. There are dissensions and conflicts and, to say the least, there is ever increasing turmoil throughout the world.

We feel, as physicians, the ever-increasing pressures of government intervention by legislation in the medical care field and the delivery of health services, and there is a great deal of conflict within our own professional ranks as to how and in which direction we should proceed. In addition to the increasing encroachment upon the free practice of medicine by increasing amounts of legislation, other groups are being looked upon as the medical establishment and this group consists of economists, sociologists and medical academicians. Organized medicine, it would seem, is faced with this very fact and must recognize it for what it is.

It is the economist, the sociologist, and others who now in this day and age have the ear of labor unions, universities and federal agencies and there is every reason to believe that this will go on.

It has been predicted that within the next thirty years or by the year 2,000 the world will have undergone such changes as to make it almost unrecognizable. These changes will be brought about by many influences, but in my estimation and the estimation of leading authorities, the most significant influence is and will be the explosion of the earth's population.

For example, in keeping with the often quoted statement "Coming events cast their shadows before," the world's population today is three billion, almost triple what it was a century ago. By 1980, the world's population will be four and a quarter billion, by 1990, over five billion, and by the year 2000, six and a quarter billion. When today's teenage children reach the age of 50, the population of the earth will have doubled. By the time they are dead, it will have tripled.

To bring the problem a little closer to the United States, the same thing will occur. Our present population is a little over two hundred million, nearly ten times what it was 150 years ago, and it is predicted that by 1990, there will be three hundred million Americans, and by 2000 there will be three hundred and sixty million.

With the growth of the human population on earth, technology has brought more and more benefits to people everywhere. Technology, for example, was the principal driving force in evolution from apes to men which began with the invention of weapons and tools. Other inventions followed which included the discovery of fire, the development of agriculture, the wheel, the harnessing of wind and water, the invention of gunpowder, chemistry, the internal combustion engine, aircraft, electric power, electronic computers, communication satellites, which have all contributed to the entire complex of modern living.

And with all this came the rapid developments in medical technology and the care and treatment of the patient. Today we observe transplantation of human organs and although there have been many reverses and there are many conflicting opinions in medical circles as to the value of such organ transplants there is no question in anyone's mind, I'm sure, that, eventually, much success will be forthcoming.

And the very fact that one new American is being born every ten seconds in these United States is an appalling fact, which we must face realistically and recognize it as something to be dealt with in terms of the future of medical organizations and medical practice.

Projecting, economically, what may occur in the future if inflation continues at its present trend, a stay in the hospital which may be now $75, in the year 2000 will be $630. A new car which now costs $4,000 will cost $9,900. A haircut which now costs $2.00 will cost $10.00. A man's suit which can be purchased for $80 today will cost in the year 2000, $270. Food for four per week which now may cost a wage earner $40 a week will cost $112. A year in college at the rate now of $2,570 will be $6,000. A $40,000 home will cost $86,000. The cost of having a baby which is about $200 today will be $640. Incomes will be up, too. A typical family with income now of $8,000 a year may have an annual income of $36,000 by the end of this

century if current trends continue.

Now what are the answers to these economic problems, the population explosion and organized medicine's role. I can assure you that for me to stand in front of you and to project solutions to these problems, of course, would be completely absurd, since I, as a single human being, couldn't begin to have the answers to such complexities, but I can, based upon what has occurred, legislative-wise and in technology, attempt to project to you some ideas which I feel will have to be seriously considered in the best interests of the future of medicine.

For example, it has been stated over and over again that American medicine is the best in the world and it has been stated by others that it is the 16th best, but these are both myths of a sort. For example, we have seen government officials inflating our infant mortality statistics and medical officials minimizing them, when what they both could be doing is analyzing them together. No matter how good American medicine is, what is important is that we all know that it can be improved.

For example, organized medicine can lay aside some of its sacred myths and it might be possible for social planners and government officials to reexamine their concepts. I feel that if there cannot be achieved some kind of relative trust, some kind of mutual respect, some kind of honest research, rather than preordained, self-fulfilling studies on both sides then medicine will not be reformed. It may be changed, but it will not be improved. This last statement I am quoting from the words of a recent young physician who spoke before the socio-economic conference in Chicago.

He further pointed out that "most recently journalists and bureaucrats have latched upon the phrase 'our non-system of medical care'" as if they had "found the ultimately devasting reply to organized medicine. It has been referred to so often that some have stated that it could easily be called the eleventh commandment. However, there is a non-system of education. For example, there are big colleges, little colleges, good colleges, bad colleges, Protestant colleges, Catholic colleges, and a non-system of food production, supermarkets, corner groceries, big farms, little farms, surpluses, scarcities, malnutrition and obesity.

"There would seem to be a non-system in everything except military service and postal delivery. As a matter of fact, we have multiple systems; in transportation, in food production, in medicine, the V.A. system, the indigent system, the private system. When things go wrong, we prefer to improve one of the components rather than set up a single system."

In our own present system of medical organization, I feel, strongly, that the need for improving our public image is paramount. On February 7, 1969, in *The Wall Street Journal* this headline appeared, "Divided Doctors Pressure for Change in Organized Medicine Is Agitating the AMA—Conservative Stands Ease; P.R. Specialist Is Hired; Staff Turmoil Reported."

The entire inference from this headline is that physicians are running around aimlessly, without leadership, without objectives and certainly without mature judgment in their non-system of organizational procedures and plans.

Philip Lesley, President of the AMA's new public relations consulting firm, has said that "The medical profession is now faced with defending itself on other people's terms. But in the arena of public attitudes, counterpunching can never succeed. In public relations, initiative is everything."

This means that organized medicine is definitely going to have to develop programs that will reflect beneficially upon itself. Good public relations comes from aggressive leadership in fields of concern, medically oriented, which affect people because people are the public.

ISMA's endeavors to push for more activity in the area of emergency medical services is a grand example of doing something. In the planning stages is a program for Indiana youth with emphasis on organizing a statewide program of outstanding speakers to get the message across on drug abuse, alcoholism, healthy sex attitudes, smoking and so forth. These and other such programs can only reflect favorably on organized medicine. And once you do something like this it's easy to tell it to the press, and they'll buy it. The preceptor program of ISMA and its public relations benefits is an excellent example. But we, as an organization will have to do more, and it means going beyond the discussing and resolving stage. And so it goes. There seems to be a continuing effort to reorganize everything into efficient, productive, proper systems of operation. In terms of assembly line, systematized medical practice, I am mindful of the armed forces sick call where the medical corpsman calls, "All men with gonorrhea, one step back for penicillin; all those with sore backs step forward for aspirin; all you "gold bricks" in the middle, back to your units."

This may be somewhat of an exaggeration but nevertheless it does systemize and utilize what might be, according to some points of view, an efficient system of medical care.

Another interesting observation is that medicine can be modernized and improved. The only difference is that when a pediatrician hires two aides to help him weigh babies and talk to mothers, medical critics see it as a clever job to make more money and they bemoan the decreased time the pediatrician spends with each child, but when a university hospital does the same thing or a government committee comes up with the idea, it becomes a creative innovation in the use of paramedical personnel.

"Creative Federalism" is a term which is being increasingly used near

the Potomac. And it would appear that the thought here is that anything of any worth whatsoever, is the sole prerogative, right, and natural privilege of the Washington planners, and *must* originate there.

It has been pointed out by the planners that paramedical people can be trained effectively to handle trivial illnesses which are so much a part of a physician's daily work. To me, as a physician, there are often times in these instances when a physician's judgment is vital and the patient requires a physician's assurance. In fact, I would say that this makes up a great deal of the physician-patient relationship and the reassurance that the patient may get well.

On the other hand, there is a place for paramedical personnel, I believe. Examples of these would be the coronary care nurse, whose profession grew naturally out of the needs of physicians and positions in hospitals.

Another example is the battlefield corpsman and neither one of these groups deal with trivial illness. Another area where I see great possibilities for paramedical people is the care of accident victims with rescue squads capable of much more sophisticated care than simple first aid. It seems to make much more sense to train a non-physician how to do a tracheostomy than to attempt to give him the judgment and the experience necessary to tell whether someone's trivial headache is tension, tumor, or any one of 20 possible entities.

Another one of the big myths in American medicine is the treatment of it as a single entity ignoring the amazing regional differences in the organization of practice. What is this supreme ignorance of what medicine is all about which leads decent, intelligent men to speak so glibly about plans and efficiency in medical care?

We've always known that from 70 to 80% of an internist's or G.P.'s work stems from the fears, worries and sadness in his patients' lives. Even a lot of what we call obvious organic illness stems from this same kind of personal malaise: the peptic ulcer or colitis that occupies the surgeon; the trauma that busies the orthopedic surgeon; the neurologic, infectious intestinal complications of alcoholism which absorbs everybody.

In reality, the practicing physician knows that the real killers of this nation—tobacco, fat, alcohol, depression—are the very easiest to detect but the hardest to eliminate. The physician knows that a patient's wife may be more effective in preventive medicine than he ever will be.

In the face of this, the planners, outside of medicine, are like all other middle-class Americans. They hope that if they devote a day to a yearly physical examination, they can eat, drink and speed the other 364 days and be safe.

A recent speaker said, "America today then is crippled by fear, ambition, and loneliness. Americans have their triumphs but they have them at a cost. They move too often. The parents live on one coast and the children on the other coast. Home is where they graduated from high school 20 years ago. Friends are the people they graduated with. Neighbors are the people who will move away next month. A cop on the beat is a face in a police cruiser. The neighborhood butcher is a pair of hands wrapping supermarket meat. The one person who keeps his links to our more personal past is the physician. The doctor alone can best meet the needs of the future by retaining the keystone of the past, his care of the patient. The physician then does hold a privileged place in society and he should participate in its problems by giving honest, imaginative consultation to those he works with in the reform of medicine.

"He may not know everything about the delivery of medical care, but he certainly knows something. He should become involved in those problems moved by community pressures and by personal concern and these could include health of larger groups including pollution, drug abuse and race relations. Let's face it. When a doctor does participate in these groups, he is being taken away from caring for his patients and care of patients. That is what medicine is all about, really. But these other areas must be attended to."

You may wonder why I took the time to set the stage of this talk in terms of a world population explosion, a developing technology which is exploding in its concepts and goals, a soaring economy, the anticipation of longer, more fulfilled lives for all of us, and the apparent turmoil which exists in attempting to resolve problems in the face of such tumultuous developments.

Organized medicine obviously is not the only profession having difficulties, but I must necessarily confine my last few remarks to our field.

Firstly, let me say that youth does have its place in our organizational structure, but let me beseech organized medicine not to abandon the wise counsel of their older, more experienced brethren. Winston Churchill, after all, did not become Prime Minister of England until he was 65 years old. We need the balance of older heads in our organization to maintain some equilibrium of concepts.

Since the commission appointments are made by the president, I feel that more careful consideration should be given to these appointments with the objective of bringing new men into the affairs of organized medicine and retaining some of the more experienced heads. This should also be done with a very practical eye at naming men to these commissions who offer potential leadership to the Indiana Sate Medical Association; men who have demonstrated. already, broad capabilities of directing the affairs of organizations in their communities and county and district societies.

In addition, if we, as an organi-

zation, are to create renewed interest in the affairs of the ISMA by our members, and I believe it is now a critical matter, we are going to have to take further steps.

One way in which this might be done is to plan, at the minimum, two Board of Trustees meetings a year in two separate districts, and notify all of the appropriate societies of the meeting, with an invitation to attend. This would involve a luncheon with the officers and the Board and participating in the deliberations of the Board.

The open invitation has always been there, of course, but this is not accomplishing the objective of creating and maintaining interest. We must go to them and be prepared to underwrite the costs of such meetings.

On the other hand we need to encourage the interest of young men in the importance of participating in the affairs of organized medicine. There is evidence that the interest is here, even though during the past two years, programs sponsored by one of our commissions at the Indiana University School of Medicine attracted a sum total of 12 medical students, which indeed is appalling.

However, we have found that appointing student representatives to our commissions has paid off in an unusual amount of interest and enthusiasm. They come to these commission meetings, when invited, and participate eagerly and enthusiastically with the group. I feel strongly that more emphasis must be placed on this particular program of participation.

We can gain their interest and hold them to continued participation. Whereas some youth want to resolve problems by taking off for "hippy" land, others in this day and age want to, more and more, come to grips with problems through the normal processes of evaluation, discussion, and action and I feel that many of our medical students fall into this category.

I would recommend that the Indiana State Medical Association give serious consideration to underwriting the costs of the officers of SAMA to attend one of the two meetings of the AMA annually. This would be further inducement to the officers to understand and work cooperatively with the ISMA.

I realize that the members of the Board of Trustees are busy and their responsibilities great, but I would re-emphasize the need for them to attend and participate in a meeting of each of their county medical societies during the period of a year. Someone has said that "what you are in on, you are not down on." The trustees could be exceedingly effective in letting the societies know that *their* interests are the deep concern of the Board.

In addition, in the original concept of commission organization, the appointment of a man from each district to each commission, it was the hope that each commission member would serve as a liaison person between the ISMA commission and like committees at the county level.

If such committees did not exist, it would be his particular responsibility to encourage the organization of such like committees at the county society level. It would also be his responsibility to meet with chairmen of the county society like committees once or twice a year to discuss particular problems appropriate to the commission, thus encouraging a mutual exchange of information and understanding. It would be my suggestion that such activity be encouraged and labeled as imperative to strengthening the structure of ISMA.

The annual County Society Officers Conference is a must, and I would suggest increasing the number of conferences to two a year, one in the Spring and one in the Fall. The association has attempted to keep county societies informed by sending them minutes of commission and trustee meetings, but here once again the mission is not being accomplished.

At County Society Officers Conferences the officers and the Board have an excellent opportunity to meet with county leaders on, if you will excuse a bit of an outworn phrase, an "eyeball to eyeball basis." This is communication at its best, and it is also internal public relations at its best.

Another matter which concerns me deeply is the present move to organize an Association of Medical Specialties. The advent of such an organization, nationally, would unquestionably dilute the already decreasing effectiveness of AMA and its affiliates. I can visualize representatives of such an organization, the AMA, and the American Academy of General Practice, for example, appearing before a national congressional committee presenting three sets of views on the philosophy of medicine on any given issue. To say the least, we would be playing into the already outstretched hungry hands of our critics.

And it would seem to me that the AMA and the ISMA already have the organizational structure for strengthening these organizations and itself by offering the facilities of the Headquarters, for example, as a meeting place for their meetings and the staff of the association to assist in administrative detail. I feel that we, who are interested in the future of organized medicine, must take the leadership in insuring that this dilution does not take place. From a practical point of view, initiation of new medical organizations to fulfill the needs would mean that most physicians would be paying dues to three or four different organizations.

In this awesome growth and expansion, let us be mindful of staff needs. We must consider the need for research specialists, information experts, data retrieval specialists, statisticians and field representatives, competent and capable of keeping us advised and alert to these changing times and situations.

We are going to have to eventually recognize these needs and as time evolves incorporate such experts into our staff function.

What this will do for us and our organization will put an end to the merely drifting aimlessly and somewhat carelessly into one chaotic and upsetting situation after another, which sends the public press and the public into spasms and contortions of twisted accusation toward us and our motives and puts us in a position of instant, ineffective, disorganized defense.

We can take the initiative and we can have at our fingertips the facts, figures and imagination to propel us to new heights of medical leadership in this complex society.

In addition, I think that in order for us to overcome the problems which will exist in the future, that we must work, cooperatively, with others to dispel the myths, folklore, antagonisms and prejudices which have existed between groups, organizations and individuals. All sides must dig deeply for the truth in order that rational producive solutions can be provided in the field of medical care and I know that physicians must take a leadership role.

It is our choice whether today will remain tomorrow, or will our tomorrow be yesterdays? We cannot remain static. We cannot hope that tomorrow will be the same as today, nor can we react so as to make tomorrow the same as yesterday. Instead we must plan for the tomorrow and endeavor to shape its course in keeping with the precepts of our knowledge in providing accessible, quality care, to all the people.

This, then, is my message to you and I urge you as county society officers and men interested in the future of private practice and organized medicine to consider these things and go forth from this meeting with a renewed, positive, personal philosophy to carry them out.

We Must Look Ahead

GERALD D. DORMAN, M.D.,
PRESIDENT-ELECT
American Medical Association

Thank you, Dr. Corcoran. Ladies and gentlemen. It's a great pleasure to be here. Not only to see some of my old friends but to meet many new ones. The reason that I wanted to speak of "We Must Look Ahead" is that we are in changing times and in times of change we have to know where we are going. We do it in our private lives but sometimes in our professional lives we get so busy that we do not really look ahead and plan where we are going. I challenge the officers of our medical societies to provide leadership—aggressive, responsible and constructive leadership—in planning and developing the future structure of medicine; in shaping the manner in which health care will be delivered to the American people and in assuring that the quality of health care never will be eroded by ill-conceived programs foisted on us and on the public by those who are assuming the role of leadership because they have reason to believe that we have abandoned it.

Abraham Lincoln once said, "If we would act anew, we must think anew and disenthrall ourselves from the outmoded beliefs and actions of the past." Now when we think anew, it does not mean that we are to discard everything that we have inherited from our forebears. Ours is a profession that goes back many years and it is a profession that has become more scientific recently and less the art which our forefathers practiced. But because they were healers, because they dealt with individuals and knew human nature, they were able to heal, to help and—where they could not heal—at least to alleviate.

Our objective is the best possible care for all our people. I think no one disagrees with that and yet we are told that we have no system of health care because we have failed in some of our areas to take care of all of our people. This is true in the inner cities, in the disadvantaged, in some rural areas where we have not been able to cover all our people and it has become a problem because we did not plan enough, long enough ahead to cover these areas.

Now one of the reasons that we have had a shortage of physicians is not entirely because we have failed but because we have been too successful. You doctors, we doctors, have been so successful that our people are expecting more of us than they actually are going to get. I had a letter the other day from Mrs. Georgiev in Romania and her letter said, "Dear Doctor: I've been referred to the International Red Cross in Geneva. Would you tell me where I could bring my son, who is 20 years old and has diabetes, so that he can have a pancreatic transplant. He's doing well on insulin but I know that in six years, he'll probably be either very sick or dead and I know that you can take care of him in the United States. Where can I get a pancreatic transplant?"

I wrote her and told her that we did not feel that a pancreatic transplant was the proper treatment for a diabetic condition that was under good control and suggested that she be in touch with some of our top diabetic specialists who could continue to guide her in the care of this man.

I had another letter. This time from a doctor in Bristol, England. He said, "I understand that you have physicians who are operating on congenital progressive myopia and I'd like to know where and by whom I could have my eyes operated on for such a condition." Unfortunately, my specialty doesn't happen to be ophthalmology so I called up the Ophthalmological Institute in New York and talked to them. They said they weren't doing that themselves, that there were one or two who had done a little of it, but what they had been doing was to cut down the pressure in the eyeball to some extent. They weren't recommending it as routine

treatment as yet because in some cases there had been further leakage of the vitreous where they got a collapse of the eyeball and had to do an annucleation. So I wrote him and suggested that he should not come to this country for that particular operation but recommended that he be in touch with one of the top ophthalmologists in London who keeps track of the progress that we are making here and in other countries. These are some of the expectations that are demanded of our profession.

Now, if any of you can remember back into the 30's and 40's, we were able to practice a different type of medicine than many of us can practice today. Then there was no problem in taking care of the patients that you wanted to take care of, getting away, catching up on your studies and contracts, attending the meetings that you had to attend and still having a little time for your family. You could put patients in the hospital because it was no problem to get them in. Times have changed. They're talked about as "the good old days," but those days are not coming again because more people want our care than we cared for in the past.

We have to look forward to where we are going and the areas that we have to cover. The doctor, the patient and the hospital are viewed as merging into one complex system. Now there are those that tell us that we have to go into a type of practice that is hospital oriented. My answer to that is when the government or anyone tells us that we have to practice medicine in one manner across this great, wide and variegated country, we're into some real trouble.

None of you would think of treating all your patients with the same treatment and, similarly, we cannot treat all our communities across this country in the same manner. I'm not at all sure that any group here in Indiana should be treated as we will have to treat some of our people in Harlem or Bedford-Styvesant in New York and I'm quite sure that what we do there cannot be transported immediately and applied either in Texas or in Montana. It has to be the decisions and the planning of the local individuals that take care of the problems that come up in their particular area.

The pressure is to put us into a complex system. There is pressure for integration because of the social drift. The agent in this integration is the government. The fuel is the tax dollar. The catalyst is the economic pressure. And the tool is the computer. You've seen some of the planning applications in the Office of Economic Opportunity, in various clinics, in various outreachings. In these areas the cost of taking care of individual patients is very often quite high. In some areas it's $600 per patient. Now I think that most of you could take care of your patients if you were guaranteed $600 per patient for all patients that are under your care. Some of them will cost more but the average, I would guess, would be considerably below that. You can buy comprehensive health care for under that figure. It is important, however, that we realize what is being considered and what the ideas are.

One of the challenges has been the regional health system. Now this was introduced at a White House Conference and some of the people there admitted that they had to start in with a program that called for heart disease, cancer and stroke because no one would want to take in everything. This is being expanded gradually. It was supposed to be a group program to show what could be done to spread the knowledge that we have and in working this out the theory was that a central hospital would be a center for teaching newly-acquired knowledge.

Dr. Hudson when he went down and spoke to the legislators in Congress got them to confine it not to care but to instruction and the work that would be instructive to the people that were in the area. This is gradually being brushed aside.

The second challenge that they are considering is the Lockheed New Star System. This is the system that they have up at the Mayo Clinic, where you can have everything done either by the computer or by an electronic system. In this you can put on your computer whatever you want to program and you can have electrical connections so that you can telephone in and get the EKG, the laboratory or x-ray reports, or you can talk with the consultant wherever he is. You can put the whole record on tape. You can have your patient monitored by wires so that you can have a running EKG, pulse, temperature and other vital signs.

I want to warn not against modernization, not against advances but against impersonalization. One of the things that our astronauts spoke of, particularly when they were up circling the moon and got those flu cases and colds, was the fact that they couldn't talk to their doctor. They had to talk through a central system. They then had to relay it to the doctor. "What did you say, doctor?" And then suggestions had to be relayed back to the patients up there circling the moon. This gave them a sense of detachment. One of the things that medicine requires, contact with your patient. If you cannot have it he may not always follow your regime and direction, and he drifts away from you. The science is there, but the art and the heart of medicine is not there to help out.

In the concept of the planners, the great central areas will have a large hospital for teaching purposes and there will be satellite hospitals around. They say this is the concept we had in the army. After all, you have your collecting stations that feed back to your evacuation hospitals and then back to your general hospitals. Why can't we do this in civilian practice? In their concept, the central hospital would be connected with a teaching institution, a university, headed by a dean who

would decide who would be on the staff. He would also decide in the satellite hospitals who the staff should be so that they could have adequate rapport. If this is to come about, then it gives the dean almost complete control in the regional area and, I am not certain that this is for the best interests of our patients in the long run.

Very often the academic community is away from contact with the people in their homes, with the problems that they have, with the problems of living quarters, of family pressures, of the various problems that pressure the patient and affect his health. This is one of the problems that we must keep in mind when we consider some of the planning that is going on.

Another pressure that we face is the doctor shortage and this is more real than apparent. We still have a large number of registered doctors, but many of our colleagues are going into full-time practice of medicine whether it is in industry or in government or in full-time jobs at hospitals and teaching. This has left a heavier load on the doctors that are caring for patients. There are other problems. I've been told that in Alaska, which I won't be seeing until June, some of the doctors are leaving because of the high cost of malpractice, they just cannot keep up with the increased premiums.

Some doctors feel that they are so overloaded in their general practice in the rural areas that they are giving up and going into specialization so that they can have a little more time to themselves, a little better income and a little better time with their families. But all of these items cut down on the men at the front—at the grass roots—that are taking care of our people.

The problem of the social planners is that they are not considering the cost, unfortunately. They say that cost is immaterial. If we can deliver it, forget about the cost. If you need a national center for health services and the cost is two billion dollars, so be it. If we do go into that area, then we are shifting our responsibility for payment to government and because I have been with the World Medical Association and chairman of the council for three years, I've known some of the problems that they've had abroad when they have depended on government. They say, "Do not let this happen in your country. We know what happens. You in the United States are our last hope for free medicine." Abroad government sets the fee schedules, the salaries that physicians will receive and then government tends to forget to keep them up to date. If we could set a salary here—a fee schedule—that would be not only 100% of what most of you would like, but perhaps 150% and if that fee schedule is locked into government, the first thing you know it becomes obsolete. Other costs compete for government dollars.

There is education, roads, maybe war, various items. Government can say "You got what you wanted. We gave you 50% over what you wanted. What are you kicking about now?" With the increasing cost of living, normal inflation, and then medical inflation which goes up faster than the normal cost of living. You have to pay your office personnel, and if you're filling out forms for Medicare and Medicaid, you also have to take on extra clerical help; your rent is going up, the malpractice rates are going up. These are above the ordinary cost of living so that you cannot say that what is satisfactory today will be satisfactory in even five years.

These are some of the dangers of getting locked into a government fee schedule. In New York where we have Medicaid and have had it for some time, on the basis of our relative value figures, the Governor decided that we should have a $5 conversion item or unit of the relative value schedule and then he said that for Medicaid patients he'd give us 80% of that figure. The doctors went along with it feeling that 80% was better than the free care which they had been giving to their charity patients. Then just this year Rockefeller said, "We'll cut 20% across the entire budget. Everything goes down 20%." Our state president Ed Hughes and Norm Moore went up to see him and said, "This cannot go on for the doctors' fees. After all you had us set our Medicaid fees at 80%." He said, "Oh, that was to start. We let you go back 10% at a time to the full $5.00." The doctors said, "I'm sorry, Governor, but that is not true. We're still held at 80%." He turned to his staff. He said, "Am I mistaken?" They said, "Yes, Governor, you're wrong." So that here it would have been a question of cutting back physician fees from 80% down to 60%. Fortunately, he saw that this was not a reasonable way of approaching it.

I cite this as an example of what government tends to do when they lock you into a fee schedule that has no automatic escalation clause and does not have any allowance for an increase on the basis of the cost of living. At this stage one might ask whether I am against all government interference. The answer is no. We have to have government cooperation on some of our projects in order to carry through and at this point I would again warn that we cannot put all our trust in government, even though in the long run government is you and me as well as our patients. We have to have private initiative and private drive as well to keep ourselves free. This means that we have to have the local initiative to decide what is needed in our area and to develop proper planning so that our area can be taken care of.

It's a little bit funny to come to Indianapolis and tell Indianapolis and the Indiana Medical Society what to do, because one of the outstanding examples of local initiative I think is what the women of Indianapolis did seven or eight years ago and thereafter, when because of the crime rate, they got together and did a beautiful

job of tackling the problem. First they checked up on the school dropouts, increased the street lighting, and gradually cut back the crime rate in this city. To these ladies I take my hat off and to the job they have done. This is the type of individual initiative that we need to apply in the care of our patients and in the work of our people.

In closing I should like to comment that there are some things that we must do and I think the first is to show that we have a sincerity of purpose. People must know what we stand for. We're out for the care of our people, not on the basis of wealth or poverty, but the best care of all of our people. We should strive for professional excellence. You were going over this in the meeting this afternoon when you were discussing continuing medical education, keeping up with the times, so that all of our doctors can give their best knowledge and best skills to our patients. We should have definite, positive policies. We should have concern for the public welfare and have workable programs—not mere words.

I would like to close with the quotation from Tom Paine, of the American Revolution: "Those who expect to reap the blessings of freedom must, like men, undergo the fatigues of supporting it." That is why it is up to us, as leaders in our medical communities, to take on this job and see it through to the best of our ability, each in his own area. Thank you.

The Medicaid Bill

WILLIAM R. STERRETT,
Administrator, State Department of Public Welfare

First I would like to add to the compliment you paid Dr. Bowen. I have observed 12 or 13 sessions of the General Assembly and I have never seen a session conducted with such dignity and decorum as the one presided over by Dr. Bowen. I don't know whether the Governor will be here today or not but he has asked me to extend my greetings and his greetings to any group who I have the privilege of addressing and he is a little perturbed about the accusation that the last session of the general assembly, and that he himself, was niggardly in appropriations. I would like now to touch on a view of the increases enacted at the last session.

Education in Indiana received $161,000,000 more than in the preceding biennium which is a 17.8% increase. Total highways received $157,000,000 more than in the past biennium or 25% more. The state police got 15% more than in the preceding biennium. Mental health got 7% more. Corrections got 18.8% more and public welfare 14.6% more . . . altogether $658,000,000 more than in the preceding biennium.

Now the principal item of business this year was the enactment of the Medicaid Bill and during the session of the General Assembly it became known as the mini-medicaid bill. That was because the bill was amended from the original introduction to include only the basic minimum requirements which would enable the state of Indiana to be eligible to continue to receive federal financial participation. The bill as originally introduced included not only all present recipients of public assistance in the state of Indiana but also medically indigent. This would have increased the cost to the state of Indiana for the 18 months of the biennium in which the bill will be effective by more than $22,000,000. By going to the mini-medicaid or the basic requirements, it includes only the present recipients of public assistance, some 72,000 in the state. Those are people receiving either money payments or medical care under the old-age assistance program, under the Kerr-Mills or medical assistance for the aged, under the blind assistance program, the program for the disabled, and the assistance to dependent children.

Now there are two exceptions to this and those include those people who would be eligible for one of these programs except they do not meet a state requirement which is more stringent than the federal and the federal has to do primarily with residences and citizenship. We must include a person 65 and over even though they have not lived in the state three of the last nine years and even though they are not a citizen of the United States. The other small groups will be certain children in ADC families who are under age 21. They are too old to receive financial assistance but can continue to receive medical care. There will be a General Advisory Committee appointed effective throughout the program which will assist in drafting plans for the operation of the program. The program will be handled through a carrier. I think this is one of the most important aspects of it, because of 92 county departments of public welfare negotiating fees, trying to let a lay person determine whether or not the person received too much service. Many of the other policing aspects which many people would attempt to do if they had the courage will now be handled by, in one sense of the word, peers of the various disciplines in the medical field.

Indiana has had the most comprehensive medical care programs for public assistance recipients of any state in the Union since January 1, 1942, and because of this we're not subject to the pitfalls that many, many other states have run into in the initiation of a Medicaid program, because to make estimates, you need to have past experience and we've had 27 years of past experience with a comprehensive program. Some of the states that run into difficulty are the states who primarily did not have past experience or very, very limited experience. One of the states, for example, had a limit of five days of hospitalization for a welfare patient a year. They limited the number of times a patient could be seen by a physician to 10 or 12 times a year. They had no prescription drugs. Well, consequently, when this state

vent into the Medicaid program, it cost much, much more than any estimate, but with our experience, we do not feel that we will have this type of situation arise.

One of the other things that we think can save an appreciable amount of money is that it is possible now for the first time for people to be placed in boarding or residential care situations instead of being placed in nursing homes. Many times in the past the person who could not live alone was placed in a nursing home even though he did not need nursing services. This was because the maximum amount that we could pay to an individual was $80. They could not buy adequate care in a boarding home for $80. These are people who need someone to be sure they get up in the morning and get dressed. They get three meals a day and don't wander around in the streets.

One of the incidents that happened recently was that a caseworker in a county department went out to see one of the recipients and they couldn't find this individual. Incidentally, they were paying $15 a day for his care. They finally found him out cutting the grass for the administrator of the nursing home. So, this person will be placed in a boarding home at a maximum of $200 a month instead of $450 a month in the nursing home. This is the reason that we estimate the total cost of the Medicaid program as less than we are presently paying for various aspects of medical care.

Now during the fiscal year ending June 30, 1968, the total cost of the administration of welfare in the 92 county departments plus the state department, including all administrative costs, all assistance payments and all medical care, this includes child welfare, crippled children and the whole gambit, was $87,000,000. The costs of medical care during that period was $29,100,000 or more than 33 1/3% of the total cost. We do not feel that it will be that much under the present program with the use of boarding homes because that will permit us to place people in the type of care they need. One of the other advantages is that skilled nursing home beds will be available to move people out of the hospitals where now, many times, they are having to stay in a hospital for $35, $40, $45, $50 a day when they actually do not continue to need hospitalization.

One of the things I would like to impress upon you is that I am not asking to win any popularity contests as administrator of the state welfare department. Many of the practices carried on by the county departments are going to be stopped. I would like to be friends with the physicians but if we see physicians who are abusing privileges, abusing practices of any other discipline, we will attempt to, with your help, police this. We're not going to police it ourselves. We think that each discipline should do his own policing. We think it's much more acceptable and we think we will have people who are knowledgeable doing it instead of lay people, and generally these are clerks in the 92 county departments trying to audit your bills and determine whether or not you gave the right amount of service and if your fees are correct. We plead for your cooperation and pledge the best possible administration that we can give. Thank you. ◄

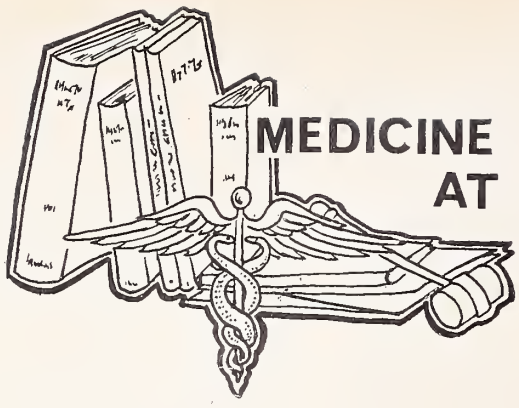
New Pamphlet

"Rh Disease," the newest pamphlet in the American Medical Association's MD-Patient Information Service series, acquaints the public with the dangers of the disease commonly described as "blood-destroying anemia of the newborn."

The four-page pamphlet states that the disease annually claims the lives of approximately 10,000 babies in the U.S. "Yet, not until 1968 was an acceptable preventive approved that may permit parents with Rh incompatibility to have more than one child without fear," it points out.

The pamphlet discusses the three commonly used methods of combating the disease and describes the new preventive treatment, called anti-Rh immune globulin.

Copies are available from the AMA Order Department at the following prices: single copies, 20¢ each; 50-99 copies, 18¢ each; 100-499 copies, 16¢ each; 500-999 copies, 14¢ each; 1,000 copies or more, 12¢ each.



Failure of Patient to Answer Interrogatories Fully—There was no abuse of discretion in a trial court's dismissal of a suit against a physician by a patient's husband for incidental damages resulting from allegedly negligent treatment of the patient, because of the husband's repeated failures to furnish information requested by interrogatories, the Rhode Island Supreme Court ruled. Since the information was readily available to the husband, it was immaterial that the information was not within his personal knowledge.

It was alleged that during childbirth the patient was given a spinal anesthetic to which she had not consented and that as a result she contracted spinal meningitis. The husband sought to recover the medical expenses that he had incurred in attempting to cure his wife's condition.

The physician served interrogatories on the husband. He asked for the name and address of each physician who treated the patient for her alleged injuries and the date of each treatment. He also asked for an itemized statement of the charges for each of the treatments on each such date.

After much delay, the husband finally filed an answer. He furnished the name and address of each physician who had treated the patient. As to three of them, he stated that he was unable to give the dates of treatment because they were unknown to him. He furnished the total bill of each physician, rather than an itemized one.

The husband was given additional time in which to make his answers responsive to the interrogatories. After another long delay, he filed another answer that was substantially the same as the first.

The husband contended that the answers were sufficient because they stated all the information that was within his personal knowledge. He said that he hadn't asked the physicians for the dates of treatment. He said that he had furnished the physician with authorization to examine all of the patient's hospital and medical records which contained the desired information and that that was all that was required by the rules.

The husband was ordered, on pain of dismissal of his suit, to obtain from the physicians all the information requested in such itemized form as it is customarily given and to furnish it to the physician. When the husband failed to comply with the order, his suit was dismissed.

The information requested was clearly relevant to the subject matter of the action. A party may not avoid interrogatories by saying that he does not know information that is readily available to him. The authorizations that were given the physician to inspect the records might well not take the place of the obtaining of information by a person having a relationship with the physician.

It was clear under the rules that the trial court had the discretionary power to dismiss the husband's suit for his failure to respond to the interrogatories. In view of the husband's repeated failures to furnish the information, there was no abuse of discretion in the trial court's dismissal of the suit.—*Hodge v. Osteopathic General Hospital of Rhode Island*, 249 A.2d 81 (R.I., Jan. 8, 1969).

Physician Entitled to Disability Benefits—A physician was entitled to benefits under the group disability income policy issued by an insurance company to the members of the American Medical Association, a federal appellate court ruled. When the physician applied for the insurance, she was engaged in the active practice of medicine on a full-time basis, within the meaning of the plan's requirement. Whether or not she intended to reestablish a full-time active practice was immaterial.

The physician practiced privately from 1949 to 1961, when she suspended her practice to undergo a back operation. During her convalescence she moved her office, making substantial investments in space, alterations, and equipment. In March, 1962, she notified her patients that she was returning to practice. She actually began seeing patients on September 7, 1962.

She applied for the insurance policy on September 24, 1962. She gave an affirmative answer to the question in the application as to whether she was actively engaged in the practice of medicine on a full-time basis. The policy specifically provided that only members of the AMA who were actively practicing medicine on a full-time basis were eligible for membership in the plan.

From September, 1962, until March, 1963, except for an absence during November and December for a neck operation, the physician spent full days at her office five days a week and additional time on weekends. She saw an average of about 20 paying patients per month, most of whom she examined exhaustively. She did much of her own laboratory work and office work. She was forced to

discontinue her practice in March, 1963, because of pain and complications resulting from the neck surgery.

The insurance company contended that summary judgment should not have been granted for the physician because a genuine issue of fact existed as to whether she had ever intended to reestablish a full-time active practice. It claimed that the issue of fact as to the physician's intent was raised by the following facts: the physician's statement that an income of $500 per month from her practice was sufficient because she was not the family breadwinner; in June, 1962, before she resumed practice, she resigned her position as director of an arthritis clinic; both before and after the resumption of her practice, she rented her new office to other physicians to use in evenings and occasional afternoons.

The physician was entitled to recover, even if that evidence could be said to be sufficient to support a finding that the physician did not intend to reestablish her practice on an active full-time basis. Since the policy was silent as to the policyholder's state of mind, it is reasonably understood to make irrelevant the question of intent.

The policy was apparently intended to cover a large number of physicians engaged in a variety of medical practices. To consider it as covering only typical practitioners would be to exclude all those whose practice in some way departs from the ordinary or falls short of the average. The more likely intention was to provide coverage for any physician who, regardless of his professional eccentricities, devotes his full working time to his practice and sees patients fairly regularly.

It was more reasonable to read the policy as establishing objective, rather than subjective, criteria for active, full-time practice. Whether a physician's practice developed according to his expectations, and his opinion as to whether his activities constitute full-time practice, would seem irrelevant to insurance coverage—*Continental Casualty Company v. Beelar*, 405 F. 2d 377 (C.A., D. of C., Nov. 26, 1968).

Chiropractic Services Are Not Medical Services—A medical care corporation was not required to reimburse chiropractors for services rendered to its subscribers, the Attorney General of Michigan ruled in a recent opinion. Chiropractors are not doctors of medicine within the meaning of the statute providing for the organization of nonprofit medical care corporations.

The statute provides that a medical care corporation shall not furnish medical care otherwise than through doctors of medicine licensed under the medical practice act, or podiatrists licensed under the podiatry practice act. The statute makes no mention of the furnishing of care by chiropractors.

Chiropractors were originally licensed to practice under the medical practice act, but were prohibited from using the title of "doctor." They are now licensed under the chiropractic practice act.

In view of the plain wording of the statute relating to medical care corporations, chiropractors are not entitled to reimbursement for services to a corporation's subscriber, unless they are also licensed under the medical practice act.

An informal opinion letter issued in 1941, in which it was stated that it would not be objectionable for a medical care corporation to reimburse a chiropractor for services furnished to a subscriber in an emergency could not be considered authorization for the corporation's reimbursement of a chiropractor for services furnished to a subscriber in a non-emergency situation.—*Opinion of Michigan Attorney General*, No. 4640 (Mich., Jan. 13, 1969).

Vitamin Preparations Condemned as Misbranded—A quantity of two vitamin preparations was condemned by a federal trial court on the ground that they were misbranded. While the tubes containing the plastic packets in which the tablets were dispensed had labels stating the information required by statute, the labels on the plastic packets did not state the required information.

The statute requires that a drug in a package form bear a label stating the name and place of business of the manufacturer, packer, or distributor, the quantity of contents in terms of weight, measure, or numerical count, and the established name of each active ingredient. The statute defines "label" as the printed or graphic material on the immediate container of the article.

Both preparations are composed of lemon bioflavonoid and ascorbic acid. They are packed in cylindrical tubes, each containing 36 plastic packets. Each plastic packet is heat-sealed and contains 28 tablets. A label on the outside of each tube states the information required by the statute. The only printed matter on the outside of the plastic packets is the preparation's name and a code number.

Since the plastic packets were the immediate containers of the preparations, the statutory requirements were not satisfied and the drugs were therefore subject to condemnation.

The provision of the statute which exempts drugs dispensed on prescription from certain labeling requirements, if specified conditions are met, was not applicable. The exemption becomes effective only at the time that the drugs are actually dispensed on prescription.—*U.S. v. Article of Drug*, 292 F.Supp. 346 (D.C., Cal., June 11, 1968).

Physician Not Liable for Misdiagnosis—A physician was not liable to a patient for alleged negligence in misdiagnosing her ulcerative colitis as pseudomembranous enterocolitis and treating her on the basis of his diagnosis, a California appellate court ruled. The evidence sup-

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ported the finding that there was no negligence on the physician's part. The doctrine of *res ipsa loquitur* was not applicable. The trial court properly excluded from evidence a drug manufacturer's brochure and the transcript of a recording in which the physician allegedly made admissions about his treatment of the patient.

The patient's medical history prior to consulting the physician was a long one and included the birth of four children, several operations, and several instances of allergic reactions. She first consulted him about thyroid trouble. An examination made after she suffered rectal bleeding disclosed hemorrhoids and a polyp in the left colon. A biopsy showed no malignancy. The rectal bleeding recurred intermittently. Over a period of several months, while under the physician's care, the patient underwent a hemorrhoidectomy, an anoplasty, and an operation on the Bartholin's gland. The physician also prescribed a number of drugs. A stomatitis and a secondary Monilia and thrush developed. The physician made a tentative diagnosis of pseudomembranous enterocolitis and treated the patient accordingly.

The patient was transferred to another hospital, where she was under the care of specialists who initially made the same diagnosis. Her condition was finally correctly diagnosed as ulcerative colitis.

The fact that the physician's diagnosis was incorrect did not necessarily mean that he was negligent. His mistake, made in good faith, was an excusable one that even specialists in the field later made.

Some of the expert medical witnesses testified that they would not have done some of the things in the treatment of the patient that the physician did. However, there was no proof that he did not act in accordance with the accepted standard of care. The following must be remembered: the physician was not and did not profess to be a specialist; his mistake in diagnosis did not in itself establish negligence; he testified that his treatment was proper on the assumption that his tentative diagnosis was correct; none of the medical witnesses stated an opinion that the physician was negligent; the only expert witness who testified that he was familiar with the standard of care applicable to the physician stated the opinion that the physician acted in accordance with that standard of care.

The physician did not, as the patient contended, have the burden of justifying his treatment of the patient under the doctrine of *res ipsa loquitur*. Since there was no evidence that there was negligence or that the physician was probably the cause of any untoward result, there was no basis for applying the doctrine.

The drug manufacturer's brochure was admitted in evidence after the physician testified that he consulted it in prescribing for the patient. The brochure was stricken when it developed that it had been printed and distributed subsequent to the physician's prescribing of the drug for the patient. This action was correct, since the brochure obviously could not have been used by the physician.

The transcript of a recording in which the physician allegedly made admissions with respect to his treatment of the patient was also properly excluded from evidence. No evidence was presented to show that the recording was made on a machine that accurately reproduced what was said. —*Allen v. Leonard*, 75 Cal. Rptr. 840 (Cal., Feb. 26, 1969).

No Mutilation of Body in Autopsy—A physician who had been authorized by a mother to perform an autopsy on the body of her son was not liable to her for alleged mutilation of the body in performing the autopsy, the Kentucky Court of Appeals ruled. The evidence established that the physician performed the autopsy in the usual and customary manner.

The mother wanted the autopsy performed because she suspected that her son's death was due to foul play, rather than a heart attack as had been reported. She gave the physician written authorization to perform the autopsy.

Several months later she employed another physician to perform a second autopsy. He also found no evidence of foul play. However, he found that the heart was missing from the body and that the brain had been taken from the head and examined and then placed in the stomach for the purpose of reburial.

The mother contended that the removal of the heart from the body and the placing of the brain in the stomach during the first autopsy constituted mutilation of her son's body.

The physician testified that, in order to substantiate his findings that the cause of death was a heart attack, it was necessary to take the heart to his laboratory to do a dissection and microscopic examination. He produced slides that established that he did do a dissection and microscopic examination of the heart.

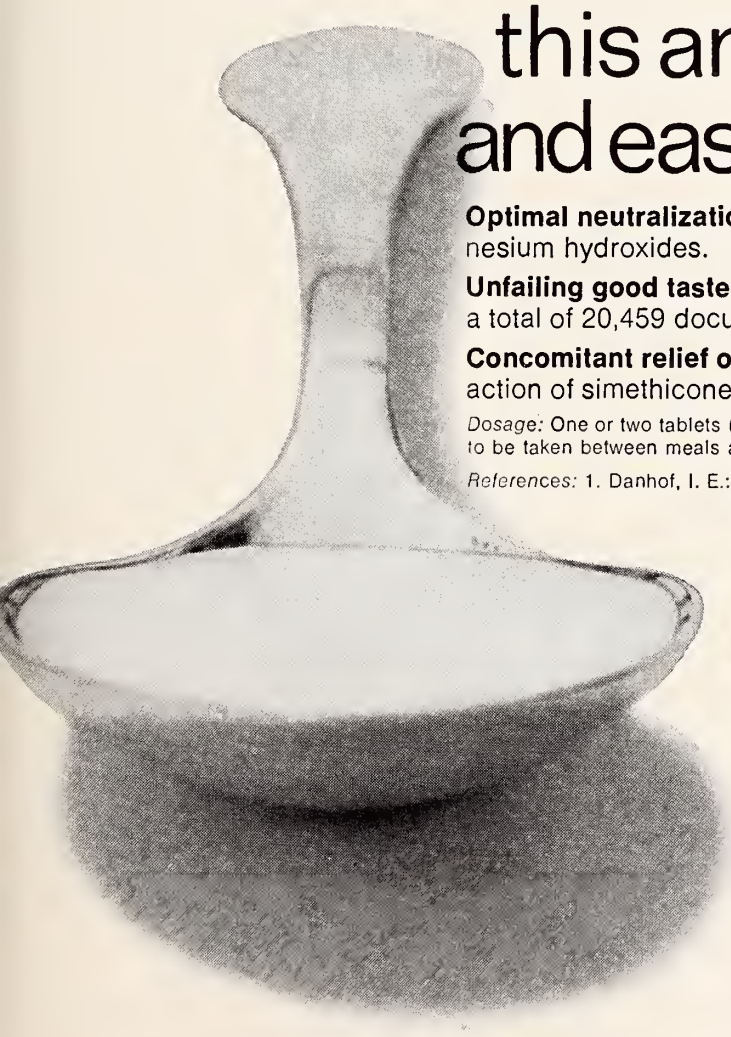
The physician also testified that in all the autopsies that he had performed he had never put the brain back in the skull because it was impracticable to do so. Since the brain was thoroughly examined and dissected after its removal from the skull, it would be difficult to restore it to its normal resting place and it would cause seepage to the outside area.

What the physician did was necessary to determine whether there had been foul play or whether the son had died of a heart attack. Four eminent pathologists testified that the physician had performed the autopsy in the manner usually and customarily used by a pathologist.—*Lashbrook v. Barnes*, 437 S.W.2d 502 (Ky., Feb. 14, 1969).

Continued

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Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonfuls to be taken between meals and at bedtime, or as directed by physician.

References: 1. Danhof, I. E.: Report on file. 2. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.

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Continued

Osteopath's Business Expense Deductions—The IRS' disallowance of various business expense deductions taken by an osteopathic surgeon on his income tax returns was considered by the U.S. Tax Court in a recent case. In some instances, the question was whether the expenditure qualified as an ordinary and necessary business expense, while in others the question was as to the amount of deduction claimed.

The osteopath's tax returns for 11 years were involved. In each of those years his gross income was between $200,000 to $300,000. The resolution of the questions involved was complicated by the general inadequacy of his books and records and by the fact that he made many payments in cash.

Disallowance of a deduction for a payment made to the osteopath's daughter as salary was affirmed; there was no evidence indicating the nature of any services rendered by her. The greater part of the claimed deduction for salaries paid to his two sons was also disallowed. Payment for their services in driving him to and from the office were commuting expenses and not deductible. A portion of the payments to them attributable to their services in maintaining the osteopath's boat, which he used in entertaining for business purposes, was deductible.

A deduction was allowed for a portion of payments made to the osteopath's father, for maintenance and repair work around the clinic, and to his mother-in-law, for recording daily receipts and banking them; however, the evidence as to the services rendered did not justify the deduction of the full amount claimed. A factor taken into consideration as to the payments made to the family members was that the purported compensation was frequently paid in a lump sum at Christmas and thus more closely resembled gifts than compensation.

The deduction of the salary of the maid at the osteopath's home was disallowed. Although she answered an average of 15 business calls a day, recording the messages and transmitting them to the osteopath, her major duties were of a non-business nature.

Deductions were allowed with respect to payments made to some other osteopaths where the evidence indicated that the payments were for services rendered. Deductions were disallowed with respect to payments to other osteopaths; in these instances, the evidence indicated that the payments were loans.

The court increased the allowable deduction for entertainment and promotion. However, it rejected the osteopath's contention that the expenses of a particular party were automatically deductible if the guests were patients, doctors, nurses, and others with whom he came in contact in the course of his work. Since a portion of the osteopath's entertainment was done on his boat, he was permitted to deduct 10% of the depreciation and insurance on the boat as a business expense.

The osteopath was permitted to deduct a portion of the amount paid for flowers sent to patients and business associates as a business expense. In determining the amount deductible, the total amounts claimed and the extensive nature of the osteopath's practice were taken into consideration.

The osteopath was allowed a deduction for that part of his travel expense attributable to trips to professional conventions and to observe operations by other surgeons. No deduction was allowed for his wife's expenses when she accompanied him on such trips, because there was no proof of the business nature of her presence.

He was not allowed a deduction for any of the expenses of his wife's car or that of his son; the cars were not shown to be used in connection with the osteopath's business.

In addition to a deduction for his business phone and a portion of the cost of his home phone, the osteopath was allowed a deduction for amounts spent in making calls from pay phones. The evidence showed that he frequently, as a matter of convenience, made business calls from pay phones.

A portion of the deduction claimed for surgical supplies purchased by the osteopath in the course of his travels was disallowed. The amount of the deduction was limited because, in view of the amounts involved, there would ordinarily be some written evidence of the transaction, but here there was none.

The cost of a typewriter for office use was disallowed as a business expense. The cost was a capital expenditure and was deductible only through depreciation.

Three hospitals where the osteopath was on staff had staff assessment loan programs. Under the programs, the osteopath was required to pay the hospital a bed assessment of $5 for each of his patients admitted to the hospitals. In exchange for his payments, he received interest-bearing notes from the hospitals in the amounts of his payments. The amounts paid under the programs were not deductible. The osteopath received the hospitals' notes in return for the payments. There was nothing in the record to show that the osteopath could not have sold or borrowed money on the notes. The fact that he thought the notes might never be paid did not give him the right to deduct them as business expense.—*Biggs v. Commissioner*, T. C. Memo. 1968-240 (Oct. 16, 1968). ◄

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For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

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ABSTRACTS, BOOK REVIEWS

HANDBOOK OF PEDIATRIC MEDICAL EMERGENCIES

Charles Varga, M.D., (fourth edition), C. V. Mosby Company, St. Louis, 1968; 694 pages; $19.75

This is another of the handbook series which has turned into a textbook, however, as the author explains in the introduction, the definition of both emergency and pediatrics is broadening. Small wonder each succeeding edition is larger!

The completeness is probably welcomed by the user. All who care for youngsters can benefit from this book.

Eighteen chapters are present. Each concerns emergency in a specific organ system or specific circumstances. I felt the ophthalmologic, fluids and electrolytes, poisonings, and procedures chapters were all very well done.

ALVIN J. HALEY, M.D.
Fort Wayne

AUTOIMMUNITY—CLINICAL AND EXPERIMENTAL

J. R. Anderson, W. W. Buchanan and R. B. Goudie, Chas. C Thomas, Sprinfield, Ill., publisher of American Lecture Series, 1967; 484 pages with numerous illustrations and an exhausive bibliography at end of each chapter; $8.50.

Even the experts in this growing field of medicine concede cheerfully their basic ignorance of just what the topic comprises or means. The authors have tried their best to be helpful; I must confess that I have had the most frustrating experiences in trying to read this volume with some modicum of understanding. I went back to a recent Ciba *Symposium on the Thymus;* also, a Ciba study on ALS (anti-lymphocytic serum). In addition I've had the pleasure of reading Dr. Peter Medawar on ALS in *Hospital Practice* (May, 1969). Also Dr. Feldman has a special communication in *Archives of Internal Medicine* for June, 1969, Vol. 123, pp. 713-18, on *Graft Rejection* that ties in with our subject.

In essence, we are trying to unravel the arcane concepts of "self" vs. "unself." What is the distinctive combination of properties that makes for acceptance of grafts and control of autoimmune disease?

This monograph confuses (at least yours truly) more than it enlightens but this is no reflection on the authors: it just reflects our lack of intelligent comprehension. Hopefully, this ignorance will be overcome, the sooner, the better. Until that happy day, I can recommend this volume only to the dedicated specialists in the field, searching for every stray scrap of knowledge. As usual, the printing, binding and the paper are good, the typographical errors conspicuous by their absence and the price is within very reasonable limits.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

THE SIDE OF THE ANGELS

John Rowan Wilson, Doubleday and Company, Inc., Dunn City, New York, 1968: 348 pages; $5.95.

The Journal probably rates this book, a novel, for review either because its author is a physician or because its scene is based on a medical hypothesis. The hypothesis is, since the genetic code has been cracked, it is possible to synthesize humans.

Peter Kras is a molecular geneticist, lately of Russia. A coworker, just before suicide, does him the distinct disservice of mailing him the key to genetic control. Just with whom to share this awful knowledge is what bothers Peter. Never bothered much by working for the Russians. Peter now doesn't want to share this knowledge with them. Only they suspect he knows and first degrade him when he's with them and then chase him when he's away.

Peter decides not to share his secret gift with the large American corporation which secretes him from Europe either. He had lots of good advice from friends and lovers—three of the latter, one innocent, one idealistic, one pragmatic (if I understand the symbolism correctly).

Anyway, Peter, the unhero, becomes a hero after many wrong turns and several hundred well written, suspenseful, sophisticated pages.

Spy story and who-dun-it enthusiasts will enjoy this novel.

ALVIN J. HALEY, M.D.
Fort Wayne

CLINICAL DIAGNOSIS BY LABORATORY METHODS

Todd-Sanford, (14th edition), revised by Israel Davidson and John Henry, W. B. Saunders & Co., Philadelphia, 1969; 1308 pages; 698 illustrations—many in color; $24.00.

In years gone by, starting with their intern days, doctors did their own lab work as a matter of routine course. Nowadays, we ORDER whatever we think is indicated. Time was when a laboratory manual was just that: a manual—a cookbook of recipes and specific technics.

Frankly, I had not *really* perused a Todd-Sanford for all too many years. This 14th edition fascinated me. I confess to plowing through it page by succeeding page. The various authors give not only the *how* but also the *why*. Any technician who really absorbed the material presented would become a fairly knowledgeable doctor! It is astounding how much medicine is compressed into this single volume.

The illustrations are numerous and superb. The colored page

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on plasmodium malariae—the true to life depiction of the results of skin tests—etc., etc.. At present prices, the $24.00 price is more than reasonable.

I do have one serious gripe. At the front and at the back, there is the periodic table of the elements. The editor of this volume has left out the going names of the elements, giving only the actual symbolic letter and the atomic number. We are all supposed to know every and each 103 of them by heart—or do we really? And also: why leave out the valences and the charge?

Nevertheless: this is a truly marvelous monograph for your working book shelf. It is a HANDBUCH masterpiece in the original Germanic sense of that much abused word. I know I'll be taking it down often.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

Abstracts From Various Literature, Prepared by AMA

PENETRATION OF GOWN MATERIAL BY ORGANISMS FROM THE SURGEON'S BODY

J. Charnley (Wrightington Hospital, Near Wigan, Lancashire, England) and N. Eftekhar

Lancet 1:172-173, (Jan. 25), 1969.

Bacteriological tests show that the fine-woven material known as balloon cloth, used extensively in Britain for operating gowns, can be penetrated by organisms from the surgeon's body. These observations were made possible by the unique circumstances of operating routinely in nearsterile air. The direct transfer of organisms from the surface of a surgeon's gown to the wound can take place even in the presence of sterile air in the operating room. This route of infection could be avoided by the surgeon's wearing a plastic apron beneath his gown or a sterile apron of fine-woven cloth over it.

THYROID CARCINOMA IN ATOMIC BOMB SURVIVORS—HIROSHIMA AND NAGASAKI

J. W. Wood et al. (Yale-New Haven Community Hospital, New Haven, Conn.)

Amer. J. Epidem. 89:4-14, (Jan.), 1969.

Fifty-one cases of thyroid cancer were found by clinical examination of members of the Adult Health Study sample of the Atomic Bomb Casualty Commission of Hiroshima and Nagasaki. The occurrence of thyroid cancer showed a significant increase with proximity of atomic bomb exposure and increase in estimated radiation dose received. Thyroid cancer in this sample did not pursue an aggressively malignant course.

MERGER OF THREE MEDICAL STAFF COMMITTEES CAN UNIFY REVIEW FUNCTIONS

M. London (Maimonides Hospital, Brooklyn, N.Y.)

Hospitals 43:81-83, (Jan. 16), 1969.

Combining the functions of medical records, audit, and utilization committees into one review body can increase the effectiveness of such evaluations and make more efficient use of staff time by giving one group the responsibility for appraising quality of care, effectiveness of hospital use, and completeness of records. Each of the major clinical departments would form a small subcommittee of the review team. Duplication of medical staff efforts would be eliminated.

DRUG ADDICTION IN PHYSICIANS

S. Garb (Department of Pharmacology, University of Missouri, Columbia)

Anesth. Analg. 48:129-235, (Jan.-Feb.), 1969.

Data on physician addiction indicated that the main addicting drug was meperidine (Demerol). The rate of physician addiction was approximately 100 times the addiction rate of the general population. Extrapolation from the data suggests that about 300 United States physicians are addicted to meperidine each year, equaling the yearly output of three average-sized medical schools.

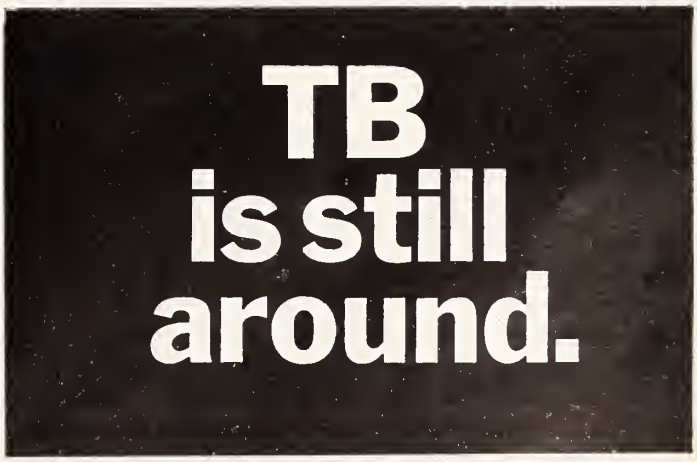
NEW CORONARY PROGNOSTIC INDEX

R. M. Norris et al. (Green Lane Hospital, Auckland, New Zealand)

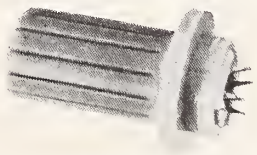
Lancet 1:274-277, (Feb. 8), 1969.

A new coronary prognostic index was constructed from numerical weightings given to six easily measurable factors which were found to be associated with hospital mortality from acute myocardial infarction. These six factors were age, ECG assessment of the position and extent of infarction, systolic blood pressure on admission to hospital, heart size and degree of congestion of the lung fields assessed from a chest x-ray, and history of previous ischemia. The relative importance of these factors was assessed in 757 patients by the method of discriminant analysis. By applying the index, patients could be divided into six groups with an increasing proportionate mortality from 3% to 78%.

Continued



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ANTIVIRAL EFFECTIVENESS OF CHLORINE BLEACH IN HOUSEHOLD LAUNDRY USE

W. E. Jordan (Product Development Division, Proctor and Gamble Co., Ivorydale Technical Center, Cincinnati), D. V. Jones, and M. Klein

Amer. J. Dis. Child. 117:313-316, (March), 1969.

The antiviral activity of sodium hypochlorite bleach during laundering of diapers soiled with feces of infants known to be shedding Sabin type 2 poliovirus, a virus resistant to the action of many germicides, was tested. Sodium hypochlorite bleach, used at the recommended bleach level of 200 ppm available chlorine, was effective in destroying Sabin type 2 poliovirus under the test conditions, which were representative of those used in the household.

HUMAN BURN SURVIVAL

H. C. Polk, Jr., W. W. Monafo, Jr., and C. A. Moyer (P.O. Box 875, Biscayne Annex, Miami, Fla.)

Arch. Surg. 98:262-265, (March), 1969.

Patients whose burns are treated by gauze dressing wet with 0.5% $AgNO_3$ recover from their thermal injury more quickly than do those receiving treatment which is not directly aimed at surface infection. LA_{50} (area of second and third degree burns resulting in death of half of the patients) for such treatment is 62% of body surface area (Berkow). Significant improvement as compared to non-antimicrobial topical therapy obtains at all ages but is most apparent in the very young and the elderly. Wound sepsis, primarily due to incomplete debridement, and respiratory injury were the most prevalent causes of death in a large group of burned individuals, half of whom sustained second and third degree burns in excess of 35% body surface area.

THE LIVER AND ORAL CONTRACEPTIVES

R. A. Hartley (USPHS Hospital, Baltimore), J. K. Boitnott, and F. L. Iber

Johns Hopkins Med. J. 124:112, (Feb.), 1969.

A rather wide spectrum of hepatic abnormalities may occur with the use of oral contraceptive tablets. Four cases are presented to illustrate some of the diagnostic difficulties which may be encountered in young women taking these drugs. Of particular interest is the case of a patient who became jaundiced while taking "the pill" but in whom the liver biopsy showed changes consistent with primary biliary cirrhosis.

HEAT LOSSES FROM BABIES DURING EXCHANGE TRANSFUSION

E. N. Hey (5 Mistletoe Rd., Newcastle upon Tyne, England), S. Kohlinsky, and B. O. O'Connell

Lancet 1:335-338, (Feb. 15), 1969.

A draught-free room heated to 28 to 30 C (82 to 86 F) provides reasonable warmth for most lightly clothed babies, but deep body temperature falls progressively when an exchange transfusion is performed under these conditions unless active steps are taken to warm the donor blood. The injection of unwarmed blood can cause selective cardiac hypothermia as well as a general fall in deep body temperature. Use of cold blood could precipitate sudden circulatory collapse during exchange transfusion.

ANGIOGRAPHIC LOCALIZATION OF INSULINOMAS: HIGH REPORTED SUCCESS RATE AND TWO ADDITIONAL CASES

H. Y. Epstein et al. (560 First Ave., New York)

Ann. Surg. 169:349-354, (March), 1969.

In two cases of benign insulinoma the tumors were localized by selective angiographic studies. A review of the literature revealed 29 patients with 30 tumors, (1.5 cm or smaller) with accurate localization by selective angiographic techniques and with a preoperative success rate of 70%. The diagnostic criterion was a small area of localized increase in vasculature which assumed a homogeneous blush two to six seconds after the onset of injection. Pitfalls in the diagnosis are the normally opacified tail of the pancreas, overlying loops of inflamed intestine, and an accessory spleen.

RECURRENT HEPATITIS ATTRIBUTABLE TO HALOTHANE SENSITIZATION IN AN ANESTHETIST

G. Klatskin and D. V. Kimberg (Department of Medicine, Yale University, New Haven, Conn.)

New Eng. J. Med. 280:515-522, (March 6), 1969.

Recurrent hepatitis leading to the development of cirrhosis is reported in an anesthetist with a history of hay fever and asthma. Each of the relapses coincided with the patient's return to work and reexposure to halothane. Challenge with a non-anesthetic dose of halothane (0.1 to 0.2%) for five minutes provoked an identical relapse characterized by chills, fever, and acute hepatitis, documented both biochemically and histologically.

METRONIDAZOLE IN TREATMENT OF ALCOHOLISM

S. B. Penick, R. N. Carrier, and J. B. Sheldon (Carrier Clinic Foundation, Belle Mead, N.J.)

Amer. J. Psychiat. 125:1063-1066, (Feb.), 1969.

Earlier investigators of the effectiveness of metronidazole in treating alcoholism have reported divergent findings. The authors tested the drug vs. placebo in a long-term, double-blind study of 100 alcoholic patients; the drug failed to demonstrate a significant positive effect on abstinence. The only positive finding was "metronidazole effect"—a decreased desire for and tolerance of alcohol—which was slightly linked with treatment success. Metronidazole may be useful as an adjunct to therapy for patients who develop this effect.

ACUTE NONCALCULOUS CHOLECYSTITIS

M. Isler (Leuget 19, Zurich, Switzerland)

Schweiz Med. Wschr. 99:115-120, (Jan. 25), 1969.

Acute noncalculous cholecystitis is a little-known clinical entity which follows so severe a course that conservative therapy is abandoned within a matter of hours or days. Over a nine-year period, 12 cases have been observed, chiefly in elderly men but also in two women and a 10-year-old boy. In six instances the disease occurred spontaneously, in three following infection, and in two postoperatively due to a vascular disorder and mechanical obstruction, respectively. In ten cases cholecystectomy was performed. In two patients, only cholecystostomy could be performed. Ten patients were cured, and two died of pulmonary embolism and septicemia, respectively. ◄

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—June, 1969

Disease	June 1969	May 1969	April 1969	June 1968	June 1967
Animal Bites	1153	1431	937	1505	1626
Chickenpox	247	637	737	185	117
Conjunctivitis	121	199	128	85	61
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	9	36	81	1	9
Gonorrhea	566	582	541	593	445
Impetigo	58	98	90	100	75
Infectious Hepatitis	41	67	53	56	36
Infectious Mononucleosis	49	118	85	53	34
Influenza	368	1284	6135	189	50
Measles					
Rubeola	15	133	108	69	60
Rubella	193	602	667	63	62
Meningitis, Meningococcal	6	5	7	8	1
Meningitis, Other	2	2	11	9	1
Mumps	236	485	461	234	509
Pertussis (whooping cough)	5	9	0	32	22
Pneumonia	146	271	241	180	204
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	386	865	1109	458	277
Syphilis					
Primary & Secondary	34	39	22	25	16
All Other Syphilis	131	118	123	142	231
Tinea Capitis	2	10	18	13	10
Tuberculosis (Active)	97	42	85	128	113

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3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

*"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.

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Thyroid Ext. (1 gr.) ....64 mg.
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Pyridoxine HCL .....5 mg.
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Major Results of Framingham Heart Study Available to Physicians

The Framingham Heart Study, a long-term prospective epidemiological investigation of cardiovascular disease, has been underway since 1949 at Framingham, Mass. A total of 5,207 men and women aged 30-62 years at entry have been examined every two years for the development of cardiovascular disease. The results of the study have greatly aided in the detection of the coronary prone adult by showing that certain traits, for example, cigarette smoking, high blood pressure, elevated serum cholesterol, and sedentary living, are associated with excess risk of developing heart disease.

The major results of the study thus far are available in a monograph series entitled *The Framingham Heart Study: An Epidemiological Investigation of Cardiovascular Disease,* edited by William B. Kannel, M.D. and Tavia Gordon. Sections 9-22, each 167 pages long, have now been completed. Section 9 gives the distribution in the cohort study by age and sex of 22 different characteristics, such as blood pressure, relative weight, serum cholesterol, etc. Each of the other sections gives the incidence of a specific cardiovascular disease by age and sex according to these characteristics. The disease categories, by section, are as follows: Section 10, *Coronary Heart Disease;* Section 11, *Myocardial Infarction;* Section 12, *Uncomplicated Angina Pectoris;* Section 13, *Sudden Death from Coronary Heart Disease;* Section 14, *Non-Sudden Death from Coronary Heart Disease;* Section 15, *Cerebrovascular Accident;* Section 16, *Brain Infarction;* Section 17, *Intermittent Claudication;* Section 18, *Congestive Heart Failure;* Section 19, *Death;* Section 20, *Death from Coronary Heart Disease;* Section 21, *Death from Cardiovascular Disease other than CHD;* Section 22, *Death from Cause other than Cardiovascular Disease.*

Copies of each section can be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, for $1.50.

Dr. Bendler Honored

Dr. Carl H. Bendler, Gary, was honored recently at a testimonial dinner and dance at the Spanish Society Inc. ballroom. Dr. Bendler plans to retire to Sanford, Fla. soon and the society presented him with a plaque and gift.

AAGP Members

Drs. Ritchie Coons, Lebanon and Henry J. Rusche, Evansville, have been re-elected to active membership in the American Academy of General Practice.

Dr. Ross is Speaker

Dr. Joseph Ross, Indianapolis, explained the hazards of smoking to young people at a recent meeting in North Central Church of Christ.

Surgery Technicians Form Association

The Association of Operating Room Technicians of Indiana recently organized during a meeting held at Methodist Hospital and attended by 120 technicians from hospitals throughout the state.

New officers are Kenneth R. Karmire, president, and Mrs. Lorene Summers, vice-president, both of Indianapolis; Miss Mary Evans, of Fort Wayne, secretary, and Mrs. Opal Farmer, of Evansville, treasurer.

Club Speaker

Dr. H. Edwin Campbell, Indianapolis, spoke on "The Stages and Changes of Women" recently at a meeting of the Marion County Extension Homemakers' Club in the City-County Building.

Dr. Donaldson Speaks

Dr. Frank Donaldson, Anderson, addressed members of the local branch of the American Association of University Women recently at the First National Bank there. Illustrating his talk with colored slides, Dr. Donaldson spoke of his experiences in a missionary hospital in India.

Speaks at Capping Ceremonies

Dr. F. Robert Brueekmann, Indianapolis specialist in orthopedic surgery, addressed capping exercises of the Marion County General Hospital School of Nursing recently in the hospital's new auditorium.

Governor Whitcomb Creates New Council on Pesticides

Governor Edgar D. Whitcomb has created an Indiana State Pesticide Council by executive order.

The council will serve as a co-ordinating body for exchange of ideas and deliberations upon uses, side effects and other features of pesticides.

It also will provide information to all groups and individuals involved with pesticides.

Whitcomb named Richard D. Bass, chief of fisheries of the Division of Fish and Game Department of Natural Resources, as chairman.

Perry E. Miller, director of the Bureau of Engineering, State Board of Health, was named vice-chairman.

Other members are Stephen Coons, administrative assistant in the office of Lieutenant-Governor Richard E. Folz; John Favinger, state entomologist; Prof. John V. Osmun, Purdue University; Frank E. Fisher, director of the Bureau of Food and Drugs, State Board of Health, and Dr. Robert B. Forney, director of the State Department of Toxicology.

Also, Dr. John E. Christian, director of Institute of Environmental Health, Purdue University; Dr. David I. Smith, secretary of the Indiana State Board of Animal Health, and Dr. Ramon B. Wilson, market service director, School of Agriculture, Purdue University.

Dr. Robertson Appointed

Dr. William Robertson, Chesterton, has been reappointed to a four-year term on the Porter County Board of Health.

Dr. Wise Speaks

Dr. Charles Wise, Camden, spoke on the medical importance of the "Word of Wisdom" or "The Lord's Law of Health" recently before a meeting of the Mutual Marrieds and Sociables of the Church of Jesus Christ of Latter-Day Saints.

Physicians Named

Drs. Joel Salon, Fort Wayne and James A. Marvel, Evansville, were delegates from the Indiana Society of Internal Medicine recently to a regional meeting of the American Society of Internal Medicine in Florida.

Knowles' Reaction Shows Him Unfit For High HEW Post, Says Bray

Congressman William G. Bray (R-Martinsville) had harsh words in response to Dr. John Knowles' latest charges that the White House under President Nixon "is in the grip of the arch-conservatives and progress is at a complete standstill." Knowles, Director of Massachusetts General Hospital, was rejected by the President for appointment as Assistant HEW Secretary for Health and Scientific Affairs, the nation's top health post.

In remarks to the House, Representative Bray said that "Dr. John Knowles' recent actions and statements, following the failure of the President to appoint him Assistant HEW Secretary for Health and Scientific Affairs has clearly demonstrated President Nixon's wisdom in refusing to appoint him."

Bray commented on Knowles' outburst, saying that "Knowles' petulant, spoiled, cry-baby attacks on the President show him as a man totally lacking in the qualities of fairness, capability, dedication and objectivity so necessary to this important post."

Eugene N. Beesley Named to PMA Executive Committee

Eugene N. Beesley, board chairman of Eli Lilly and Company, is one of two new members of the Executive Committee of the Pharmaceutical Manufacturers Association. Mr. Beesley has been a member of the PMA Board of Directors for many years and has served as board chairman. James D. McNitt of Bristol Laboratories is also a new member of the Executive Committee.

The PMA Board of Directors is chaired this year by the president of Chas. Pfizer & Co., John J. Powers, Jr. The chairman-elect is W. H. Conzen of Schering Corporation. George W. Orr, Jr., group vice president of Miles Laboratories, is also a new member of the PMA Board.

Dr. King Elected

Dr. Charles R. King, Anderson, has been elected to the board of directors of the First National Bank of Madison County.

Dr. Lanning Named

Dr. R. Adrian Lanning, Noblesville, has been named president and chairman of the 1969 fund drive of the Hamilton County Heart Association.

Dow Announces New Designation For Indianapolis Health Operations

The Division of Dow Chemical known until recently as Pitman-Moore has been redesignated as The Dow Chemical Company, Rx Pharmaceuticals.

Sale of the Pitman-Moore name and the veterinary pharmaceutical line to Johnson and Johnson will leave the human health field and pharmaceutical line with the Dow Company in Indiana. Dow Life Sciences organization will continue to utilize the Indianapolis and Zionsville laboratories for production of human health pharmaceuticals as previously.

Physicians Named

Dr. Julius J. Deur, Lafayette, has been re-elected president of the Lafayette Board of Health. **Dr. Harry E. Klepinger,** city health officer, was also re-elected to the post of secretary.

Dr. Mukhtar Elected

Dr. Fuad A. Mukhtar, Lebanon, was elected president of the Roswell Park Surgical Society at a recent meeting in Atlantic City. The society was created for the advancement of surgery in the treatment of malignant diseases.

Dr. Comer Speaks

Dr. Kenneth E. Comer, Mooresville, spoke recently before the Drama Department of the Martinsville Department Club. He gave a slide presentation of Piper Memorial Hospital at Kapanga in the Congo, where he was stationed through four periods of voluntary medical service.

Caleb Fiske Prize Essay Contest Subject Announced

The Trustees of America's oldest medical essay competition, the Caleb Fiske Prize Essay of the Rhode Island Medical Society, announce as the subject for this year's dissertation "Medical Education In The Years Ahead." The essay must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of $500 is offered. Essays must be submitted by December 15, 1969.

For complete information regarding the regulations write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence, Rhode Island 02903.

Continued



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Continued

Medical Staff Elections

Dr. Martin J. Bender, Evansville, has been elected president of the medical staff at St. Mary's Hospital there. Other new officers include **Drs. Robert Lee Harris,** vice-president and **W. Thomas Spain,** secretary-treasurer.

Dr. Williams Reappointed

Dr. Berniece Williams, Fort Wayne, has been reappointed to the Board of Health there for a four-year term.

Dr. McClure Speaks

Dr. Stanley E. McClure, Monon, spoke on "Birth Defects" recently at the annual March of Dimes dinner meeting held in Monticello.

Opportunity for Physicians to Evaluate Laboratory Proficiency

An opportunity for physicians to evaluate their own laboratories' proficiency and quality control now is being offered in a new Office Laboratory Proficiency Evaluation Program designed by the College of American Pathologists for general practitioners, internists, pediatricians, and others.

Russell J. Eilers, M.D., chairman of the CAP'S Standards Committee, said the Proficiency Evaluation Program is directed to the physician who does limited laboratory work for his patients and to small group practices which have laboratories providing limited laboratory services.

Each mailing will contain: (1) A whole blood specimen for a hemoglobin determination, (2) a lyophilized chemistry specimen for a glucose and BUN determination, and (3) a lyophilized urine specimen for specific gravity, protein, reducing substances, bile, and hemoglobin.

Cost of the 1969 testing packet is $45 and includes two mailings of specimens—one in September and the other in November.

Doctor Eilers explained that the office laboratory program will endeavor to insure high quality laboratory services to patients through interlaboratory evaluation, and "participation will demonstrate a physician's desire for quality laboratory work and the highest standards of patient care.

"It also will serve as an external quality control program," he said, "and assist the laboratory in evaluating currently used methodology and procedures. It will indicate outdated methodology and pinpoint the need for change through a list of corrective steps coded in the evaluation report."

For many years the CAP has been the leader in proficiency testing programs and now has the largest continuous survey programs in the world.

Further information on the 1969 Office Laboratory Proficiency Evaluation Program may be obtained from the CAP, 230 N. Michigan Ave., Chicago, Ill. 60601.

Physician Named to Board

Dr. Charles H. Ade, Lafayette, has been named to the board of directors of the Lafayette Bank and Trust Co.

On Hospital Board

The University Heights Hospital board of directors has elected new officers for the coming year. **Dr. John O. Butler, Indianapolis,** was named secretary.

Physicians Elected

Dr. C. L. Wise, Camden, has been named chairman and **Dr. T. Neal Petry, Delphi,** secretary of the Carroll County Board of Health.

Compromise Settlement Reached In Civil Antitrust Action

A compromise settlement in a civil antitrust action has been reached between the U. S. Department of Justice and the College of American Pathologists after the Federal Antitrust Division agreed to settle the three-year-old suit.

President Oscar B. Hunter Jr., M.D., of Washington, D.C., said the College entered into the proposed consent decree "when the Justice Department advised us of a favorable compromise to dispose of the action dating back to 1966." The decree was filed in U.S. District Court in Chicago (Judge James B. Parsons) and is expected to become final in 30 days.

"The settlement in no way," said Doctor Hunter, "constitutes an admission by the college of any of the charges in the complaint or any violation of the law. The college has always contended, and still maintains, that its activities were in the best interests of patients and in full compliance with the antitrust laws.

"The settlement simply represents a compromise, and thus disposes of a matter which would have diverted substantial energies of the college and its members from their primary duties of contributing significantly to the care of sick patients and to the prevention of illness and disability.

"Furthermore, it obviates the necessity of spending a great deal of time and money by both sides on this case."

The 1966 suit had charged the college with alleged price-fixing and boycott agreements to keep non-members out of the medical laboratory business.

Under the decree the college will continue to set standards of operation of clinical laboratories and to inspect and accredit them in its ongoing effort to assure patients and their physicians of the highest quality service.

The college also will continue to police its own ranks, imposing sanctions on a member if he has been found guilty of professional misconduct or deficient in moral character or professional competence. Further, the college will continue to require that its members report results of laboratory tests only to physicians and others permitted by law to receive such results.

And the college's objectives, under the consent decree, will remain unchanged: (1) To foster the highest standards in education, research, and the practice of pathology; (2) to advance the science of pathology and to improve medical laboratory service, and (3) to maintain the dignity, precision, and efficiency of the medical specialty.

The decree seeks to insure that the college does not insist upon or suggest fee schedules; does not restrict or prevent anyone from owning or operating a laboratory or from referring specimens to any laboratory; does not boycott any person associated with any laboratory, or does not impede anyone from accepting advertising or exhibits from any person.

Doctor Hunter emphasized that the college had never engaged in any of these practices alleged by the government in its suit, and the college "is not now, nor has it ever involved itself in any activities unbecoming to a professional organization.

"The college plans not only to continue its wide range of activities in improving and broadening medical care for patients, but also to expand its 'programs of excellence' for raising laboratory standards and services for the benefit of patients and its member-physicians."

Give Health Talks

Members of the Hendricks County Medical Society, the Optimist clubs of Danville, Avon and Plainfield, school nurses and public heath nurses combined their efforts recently to present a program of health education to the boys of the sixth grades.

Physician speakers included **Drs. Lloyd S. Terry, Danville; Robert W. Kirtley, Danville; Fred Warbinton, Plainfield; Carl Heinlein, Danville; John P. Calhoon, Avon and Joseph Kerlin, Danville.**

New Fellows

Drs. J. Thomas Benson, Indianapolis and Alfred J. Kobak, Jr., Valparaiso, were installed as Fellows of the American College of Obstetricians and Gynecologists early this year at the group's annual meeting in Florida.

Medical Staff Officers

Dr. James M. Easter has been elected president and **Dr. Guido P. Wilhelm** vice-president of the Henry County Memorial Hospital medical staff. **Dr. Donald E. Vivian** was elected secretary. All of the officers are from New Castle.

"Before the Emergency" Documentary Now Available to Physicians

"Before the Emergency," a 28-minute documentary produced by Employers Insurance of Wausau, has been selected "Safety Film of the Year." It illustrates the unpreparedness of most American communities for the proper treatment of accident victims.

Color prints of "Before the Emergency" are available on loan to medical organizations by contacting Modern Talking Pictures Corp., 1909 Prudential Plaza, Chicago 60601.

Speaker Before Group

Dr. John I. Nurnberger, of the I.U. Medical Center's Department of Psychiatry, spoke on "Drugs—Their Use and Abuse" before the annual meeting of the Visiting Nurse Association of Indianapolis.

Dr. Martz Named

Dr. B. L. Martz, director of the Lilly Laboratory for Clinical Research at Marion County General Hospital, has been named president of the hospital's staff society. Others elected include **Dr. Robert Jenkins,** vice-president; **Dr. John D. Miller,** secretary and the hospital's director, **Dr. Arvine G. Popplewell,** treasurer.

Dr. Williams Speaker

Main speaker for the recent meeting of District Two of the Indiana State Nurses Association in Gary was **Dr. Alexander Williams, Lake County coroner.** His topic was "Forensic Medicine."

Continued

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New Director of American College of Chest Physicians

Dr. Alfred Soffer, editor-in-chief of "Diseases of the Chest," and professor of medicine at Chicago Medical School, has assumed the position of executive director of the American College of Chest Physicians.

Dr. Soffer will succeed Mr. Murray Kornfeld, who has been executive director since the college was founded in 1935, and who will become the executive trustee of the college. Dr. Soffer, who is a native of South Bend, is the author of many books and was senior editor of *JAMA* for six years.

Dr. Bloss Named Fellow

Dr. Bryant Bloss, Evansville, has become a Fellow of the American Academy of Orthopaedic Surgeons. He was one of 349 Fellows inducted in recent ceremonies in New York.

Dr. Peare New Health Officer

Dr. Reeve B. Peare, Huntington, has been appointed Huntington County Health Officer. He replaces **Dr. Carl S. Ray,** who is currently practicing in Indianapolis.

The Matthews are Leaders

Dr. and Mrs. Burleigh Matthew, Indianapolis, were resource leaders at a recent Missions Day at the Yeoman United Methodist Church. Dr. Matthew also preached at the Sunday morning worship hour, speaking on "Operation, Better Understanding."

Dr. Peyton Speaks

Dr. Frank W. Peyton, Lafayette, spoke on the question of whether or not to legalize abortion in Indiana at a recent meeting of the Tippecanoe County Young Republicans.

Dr. Sabin to be President of Weizman Institute of Science

Dr. Albert B. Sabin will be the president of the Weizman Institute of Science in Rehovoth, Israel, beginning January 1, 1970.

His associates in Cincinnati will continue his work on the relationship of viruses to human cancer, and he will return periodically to advise them. His particular research project now is an attempt to find a virus in human sarcoma and associated leukemia.

Dr. Moayad is Speaker

Dr. Cyrus Moayad, Valparaiso, showed slides taken in Africa and spoke on his jungle work with Dr. Albert Schweitzer before the Lions Club Family Night program recently.

Dr. Ellett Appointed

Dr. John Ellett, Jr., Coatesville, has been appointed to the Putnam County Hospital Board of Trustees.

New Staff Officers

New medical staff officers of St. Joseph's Hospital, South Bend, for the coming year are: **Drs. Vern L. Lester,** president; **Eldon L. Gerig,** president-elect and **David L. Spalding,** secretary-treasurer. All of the new officers are from Mishawaka.

Dr. Johnson Named AAGP Field Secretary

Dr. Thomas W. Johnson, formerly in general practice i Dyersburg, Tennessee, has joined the staff of the American Acad emy of General Practice as field secretary of the Division o Education.

He will work with medical schools and teaching hospitals i setting up undergraduate and graduate residency programs in th new specialty of family practice.

Dr. Franke is Speaker

Dr. Gordon Franke, Fort Wayne, spoke on "Drug Misus from the Physician's Point of View" at the third annual Man chester College Health Conference.

Dr. Klepinger Named

Dr. Harry E. Klepinger, Lafayette, has been elected presi dent of the Board of Medical Registration and Examination fo the state of Indiana.

Dr. O'Brien Speaks

Dr. F. E. O'Brien, Rensselaer, presented a lecture on body systems, how they function and how they relate to each othe at recent sessions of the sixth grade science sections at Lafayette

Heart Fund Speaker

Dr. William Nasser, Indianapolis, spoke at the kick-off luncheon of the Sullivan County Heart Association recently. Dr Nasser is a Terre Haute native and cardiologist at the I.U. Medica Center.

Hospital Ship HOPE Sails For Tunisia Late this Month

The hospital ship HOPE will sail for Tunisia late this month for a ten-month stay. This will be her first return to Africa since the voyage to Guinea in 1964. HOPE'S tenth anniversary will be celebrated while on this voyage.

During her eight previous trips, the ship's staff has trained more than 5,100 doctors, nurses and paramedical personnel. One of the principal reasons for choosing Tunisia was the Tunisian's cordial invitation and the opportunity for training of medical students, interns and residents of that country.

Dr. Willard Named

Dr. Richard Willard, Bluffton, has been named Wells County chairman for the Indiana Future Farmers of America Foundation.

Dr. Van Fleit Speaks

Dr. William Van Fleit, South Bend, spoke on the recent advancements made in heart and artery surgery before a recent meeting of the Angola Rotarians.

Dr. Cannon Shows Films

Dr. Daniel Cannon, New Albany, showed two films on early detection of cancer at a recent meeting of the Christian Mothers of St. Mary of the Knobs.

Speaker at Meeting

"Diet and Uremia" was the topic of **Dr. Robert Devetski, South Bend,** when he spoke before the North Central Indiana Dietetic Association meeting recently.

Drug Industry Biochemist Wins 1969 Passano Award

The 1969 Passano Award goes to Dr. George H. Hitchings, vice-president in charge of research at Burroughs Wellcome, for his leadership in medical research.

The award, worth $7,500, is given annually to encourage medical science and research. Of the 29 persons who have shared the award since 1945, six have subsequently received the Nobel Prize.

Abortion Laws Debated

A recent debate on abortion laws in St. Pius X Church auditorium, Indianapolis, pitted **Dr. Irving Rosenbaum,** assistant professor of pediatrics at the I.U. Medical Center who favors liberalization against **Dr. Paul Muller,** chief of the medical staff at St. Vincent's Hospital, who took the opposing view.

Dr. Tether Speaker

Dr. J. Edward Tether, Indianapolis, head of the Myasthenia Gravis Research Department at I.U. Medical Center, spoke recently before the quarterly meeting of the Myasthenia Gravis Foundation in Indianapolis.

New Staff Heads

New officers of the medical staff of St. Joseph Memorial Hospital, Kokomo, are: **Drs. Myrle E. Artis,** president; **Jack W. Higgins,** vice-president and **D. J. Wagoner,** secretary.

Jointly Owned Company Formed For Research and Engineering

Syntex Laboratories and Optics Technology, both of Palo Alto, are forming a jointly owned company to conduct research and engineering in the medical instrument field.

Syntex is forming another company for marketing the instruments which will be manufactured by Optics Technology.

Physician Honored

Dr. Ray Shanks, Noblesville, was recently honored by the Noblesville Kiwanis Club for 40 years of perfect attendance at meetings.

Dr. Snively Speaker

Dr. W. D. Snively, Jr., Evansville, spoke on his new book, "Satan's Ferryman" at a recent meeting of the Reitz History Club.

Mental Health Speaker

"Mental Health and Violence in Our Current Society" was the subject of **Dr. William Murray, New Castle,** when he spoke at the annual meeting of the Clinton County Mental Health Association.

Dr. Irwin Speaks

Dr. Glenn W. Irwin, Jr., dean of I.U. School of Medicine, was a member of a panel discussion on the subject of "The Crisis in Medical Education" for the Annual Meeting of the American Society of Internal Medicine, in Chicago. Dr. Irwin discussed "The Hospital Years" portion of the discussion.

Dr. Hogle Appointed

Dr. Frank D. Hogle, Westville, has been appointed area chief of the special care units of Beatty Memorial Hospital.

Dr. TerBush Speaks

Cass-Carroll county medical assistants met at Logansport recently to hear **Dr. E. L. TerBush** present a talk on "Drug Abuse." He spoke on narcotics, stimulants, sedatives and hallucinogenic drugs, their differences and problems encountered with each.

Dr. Bloss Named

Dr. Bryant A. Bloss, Evansville, has been elected president of the board of directors of the Southern Baptist Hospitals, Inc. He is the first physician to ever be elected to this post.

Dr. Sims Speaker

Dr. Larry Sims, Evansville, spoke on "The Peculiar American" at a recent meeting of the First District Medical Assistants Association there.

International Fellowship in Clinical Pharmacology Awarded

Merck Sharp & Dohme International Fellowships in Clinical Pharmacology for 1969 have been awarded to four physicians from Czechoslovakia, Italy, Japan, and Mexico.

The fellowship program was begun in 1964 to help relieve the worldwide shortage of clinical pharmacologists. The grants finance up to two years of study in the United States for each appointee. The grants are awarded in each case to scholars who expect to return to their own country for a career of research or teaching.

Dr. Kennedy Honored

Dr. Robert H. Kennedy, former Director of Field Program Committee on Trauma, American College of Surgeons, has received a special Certificate of Commendation from the Public Health Service.

Dr. Kennedy has frequently been a guest in Indiana as an advisor on emergency care programs. He retired from private practice in 1960 to head the college program and did so until his retirement last November.

Dr. Oliner Named

Dr. Leo Oliner, Indianapolis, professor of medicine at Indiana University School of Medicine and director of the metabolic research laboratory of the Indianapolis VA hospital, has been appointed chief of the Veterans Administration research in endocrinology and metabolism. In addition to his administrative responsibilities Dr. Oliner will continue his research at the VA hospital in Washington, D.C.

Dr. Hanlon Director-Elect

Dr. C. Rollins Hanlon, professor of surgery at St. Louis University School of Medicine, has been named director-elect of the American College of Surgeons. He will succeed Dr. John Paul North when Dr. North retires next October. ◄

From *The Journal* 50 Years Ago

That low grade infections in the body have an important bearing on the development of kidney degenerations no one, today, will question. Sinus infections, apical abscesses, diseased tonsils, chronic pulmonary infections, diseased gallbladder and urinary infections are the more common conditions that are considered to have a direct bearing on the development and progress of kidney degenerations.

It is the relation of this latter etiological factor in the development and progress of nephritis that I wish to discuss.

Urinary tract infections frequently give rise to no symptoms which suggest their presence, hence it must be looked for in the urine, a very simple procedure in the male but requiring catheterization in the female. Pus, of course, in the urine gives the clue.

Kidney and bladder infections are comparatively common in childhood and at times very difficult to cure. It would be interesting to follow these children through to adult life. Of course for this purpose a permanent clearing house for case records would be necessary. However in adults we can study (1) the effect of urinary infections in individuals whose kidneys are apparently normal; (2) the effect of urinary tract infections in individuals whose kidneys are already damaged.

The progress depends (1) on our ability to get rid of the infection; (2) on the amount of undamaged kidney substance left. It should be borne in mind that even though the infection cannot be entirely overcome, persistent treatment will delay destruction of kidney substance and prolong life . . . . Charles G. Beall, M.D., Fort Wayne, "Urinary Tract Infections," *JISMA*, August, 1919.

★

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Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION CLINICAL CONVENTION
Date Nov. 30-Dec. 3
Place Denver, Colo.

NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville

INDIANA ROENTGEN SOCIETY, INC.
Date March 1, 1970
Place Holiday Inn East, Indianapolis

INDIANA ACADEMY OF GENERAL PRACTICE
Date April 14-16, 1970
Place Indianapolis

INDIANA DENTAL ASSOCIATION
Date May 13-16, 1970
Place Indianapolis Hilton Hotel, Indianapolis

INDIANA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS
Date May 6-7, 1970
Place Stouffer's Inn, Indianapolis

BONE AND JOINT CLUB
Date October 22, 1969
Place The Athenaeum, Indianapolis

INDIANA SOCIETY OF ANESTHESIOLOGISTS
Date May 23, 1970
Place Marott Hotel, Indianapolis

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date May 6-8, 1970
Place Morris Inn, South Bend

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 13-16, 1969
Place Indianapolis

INDIANA HOSPITAL ASSOCIATION
Date October 15-17, 1969
Place Center for Continuing Education, University of Notre Dame, South Bend

INDIANA STATE NURSES ASSOCIATION
Date October 16-18, 1969
Place Civic Auditorium, Evansville

INDIANA ASSOCIATION OF PATHOLOGISTS
Date December 6, 1969
Place Indianapolis Motor Speedway Motel, Indianapolis

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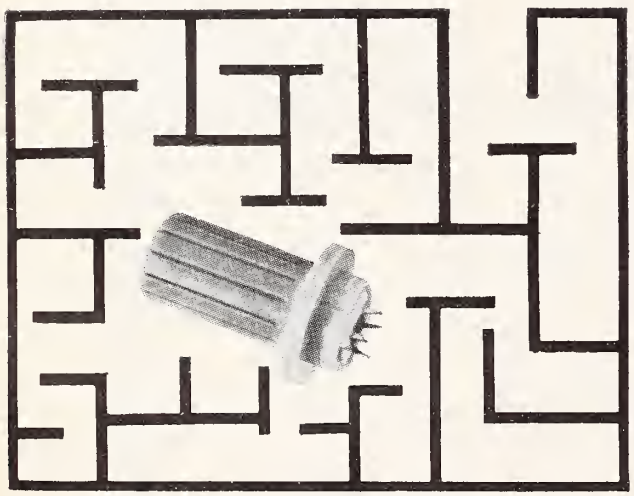
Wells County Clinical Conference on Amyloidosis

An International Symposium on Primary Amyloidosis will be the program for the Wells County Medical Society Fall Clinical Conference on September 29. It will meet at the Dutch Mill at 2 p.m.

The afternoon program will consist of several 15-20 minute presentations. There will be a social hour and a dinner. The symposium moderator, Dr. Alan S. Cohen, of Boston University will be the dinner speaker.

Participants, in addition to Dr. Cohen, will be Dr. Corino Andrade of Portugal; Dr. Maurice Van Allen of Iowa City; either Dr. Victor McKusick or Mr. Jack Nissim of Baltimore; Dr. Ezra Sohar of Tel Aviv, Israel; Dr. Walter D. Block and Dr. Charles E. Jackson of the Caylor-Nickel Research Foundation.

Tentative arrangements have been made for the participation also of either Dr. S. Araki or Dr. Y. Kuroiwa of Kyushu University, Japan. Members of ISMA are cordially invited and are requested to send reservations to Dr. Louis F. Bradley, Secretary, Wells County Medical Society, 303 S. Main St., Bluffton 46714.



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Mayo Clinic Announces List Of Postgraduate Courses

The Mayo Clinic will conduct a postgraduate course on "Venou and Lymph Disorders of the Lower Extremity" on September 1 and 19. Registration will be limited.

Send the $60 tuition fee as soon as possible to Postgraduat Courses, Mayo Clinic, Rochester 55901.

Future courses listed are "Vascular Diseases" on October 1 to 4 "Clinical Reviews" on November 3 to 5 and 10 to 12, "Neurology for Internists" on March 23 to 26, 1970 and "Heart Failure" or May 14 to 16, 1970.

Pediatrics Postgraduate Conference Set for September

A Pediatrics Postgraduate Conference will be conducted at the University of Iowa in Iowa City, on September 10 and 11. Members of ISMA are invited.

Write the Director of Postgraduate Education, 100 F. Westlawn, Iowa City 52240, for registration forms, complete program and guest accommodations.

University of Kentucky Announces Series of Programs

The University of Kentucky at Lexington announces a series of programs conducted by the continuing education department at the Albert B. Chandler Medical Center.

November 13 and 14, 1969—Surgical Care of Trauma.
December 19 and 20, 1969—Practical Ophthalmology for the Generalist.
January 21, 1970—Gastrointestinal and Biliary Tract Surgery.
January 29-31, 1970—Modern Methods for the Medical Work-Up.
March 18-20, 1970—Advanced Hematology Techniques.
March 18-20, 1970—Head and Neck Disorders in Children.
April 17-18, 1970—Mechanical Ventilators.
April 22, 1970—Diagnosis of Surgically Correctable Disorders.

Respiratory Problems in the Newborn Symposium will be in November

The Department of Pediatrics, University of Louisville School of Medicine presents its third annual Newborn Symposium, November 6-7.

Participants (alphabetically): Drs. Donald Buckner, Lawrence Davis, Peter Gruenwald, Marshall Klaus, Nicholas M. Nelson, and William A. Silverman. For information write: Dr. Billy F. Andrews, 323 E. Chestnut, Louisville, Kentucky 40202.

Mound Park Hospital Third Annual Conference

The Third Annual Postgraduate Conference on "Today's Hospital Problems: An Interdisciplinary Approach" will be held at St. Petersburg, Florida, on November 12 to 15.

The program is acceptable for 20 accredited hours by the American Academy of General Practice. Address inquiries to M. A. Barton, M.D., President, Mound Park Hospital Foundation, St. Petersburg 33701.

Sixth Annual Hospital Medical Staff Conference

The Hospital Medical Staff Conference will be held for the sixth consecutive year at the YMCA Conference Center, Estes Park, Colorado. It is designed for physicians who are leaders of the community hospital medical staff.

Tuition for the five-day conference, September 29 to October 3, is $90. For a detailed program and housing information write Office of Postgraduate Medical Education, 4200 E. Ninth Ave., Denver 80220.

Tenth Annual Cardiovascular Symposium Set for Florida in September

The Tenth Annual Cardiovascular Symposium of the Tidewater Heart Association will be held at the Williamsburg Lodge and Conference Center, Williamsburg, Virginia on September 5, 6 and 7.

Three half-day sessions are planned. The registration fee is $25. For full details and room reservation forms write the Association at 523 Boush St., Norfolk, Virginia 23510.

Conference on Sex Education Set for August 15-17 at Chicago

"Where Should We Go in Sex Education—A Search for Perspectives" is the theme for a Friday, Saturday, Sunday, August 15, 16, 17, 1969 Sex Education Conference at the Conrad Hilton Hotel in Chicago.

The Comprehensive Medical Society (formerly: The International Society for Comprehensive Medicine) is sponsoring the conference as a part of their program of continuing education.

Marshall McLuhan, Ph.D., noted communications theorist of the Center for Culture and Technology, University of Toronto, Ontario, Canada in following the theme of the conference will speak on "The End of Sex" at the Saturday, August 16 banquet.

Iowa Heart Association Sets Cardiovascular Symposium

The Iowa Heart Association will conduct a Cardiovascular Symposium at the University of Iowa Health Center in Iowa City on Friday and Saturday, September 19 and 20.

A general session will open the meeting and will be followed by simultaneous sessions on pediatric cardiology, auscultation of the heart and laboratory aids in cardiovascular disease. Dr. William B. Bean will be the luncheon speaker. ◄

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Deaths

Frederick P. Buche, M.D.

Dr. Frederick P. Buche, practicing physician in Richmond for 50 years, died June 27 at the age of 88.

Born in New Albany, Dr. Buche was graduated from the University of Louisville School of Medicine in 1905. A member of the ISMA 50-Year Club, a Senior Member of ISMA, and a member of the Wayne-Union County Medical Society, Dr. Buche was retired and had been ill for some time.

Bertram Duckwall, M.D.

Dr. Bertram Duckwall, 80, Vigo County Health Commissioner, died July 7 in Union Hospital at Terre Haute.

Born in Indianapolis, Dr. Duckwall earned his medical degree from the University of Michigan School of Medicine. In 1959, Dr. Duckwall moved to Clay County where he served as deputy coroner. He was elected coroner in 1962 and became Vigo County Health Commissioner in 1967. He was a member of the Vigo County Medical Society.

Lawrence F. Fisher, M.D.

Dr. Lawrence F. Fisher, 79-year-old pioneer radiologist, died June 13 at South Bend.

Graduated from Rush Medical College in 1914, Dr. Fisher had lived in the South Bend area for more than 50 years, serving as radiologist for several southern Michigan and northern Indiana cities. He was a veteran of World War I, a Senior Member of ISMA, member of the 50-Year Club and the St. Joseph County Medical Society.

Leslie W. Freeman, M.D.

Dr. Leslie W. Freeman, 53, Betsey Barton professor of surgery and director of the surgical experimental laboratories at the I.U. School of Medicine, died July 7 at Indianapolis.

Dr. Freeman, a founder of the National Paraplegia Foundation, was graduated from the University of Chicago School of Medicine in 1943. He was a fellow of the American Association for the Advancement of Science and the American College of Cardiology. His work in neurological research had won world-wide recognition and he was the recipient of many distinguished awards and plaques. Dr. Freeman was a member of the Marion County Medical Society.

John M. Hoyt, M.D.

Dr. John M. Hoyt, director of the Howard County Guidance Center for the past 11 years, died July 2 in St. Joseph Memorial Hospital. He was 63.

Dr. Hoyt, graduated from the University of Geneva in 1935, went to Kokomo in 1957 from the Beatty Memorial Hospital at Westville. Before going to Beatty Hospital, he served as psychiatrist on the staffs of hospitals in New Hampshire North Carolina and Massachusetts. Dr. Hoyt was a member of the Howard County Medical Society.

John K. Leasure, M.D.

Dr. John K. Leasure, retired eye, ear nose and throat specialist, died July 8 in Indianapolis at the age of 78.

Dr. Leasure retired 11 years ago after more than 40 years of practice. Graduated from the I.U. School of Medicine in 1918. Dr. Leasure was formerly an associate professor at the I.U. Medical Center and had developed some medical instruments which were named for him. He was a Senior Member, member of the 50-Year Club and the Marion County Medical Society.

Alfred A. Thompson, M.D.

Dr. Alfred A. Thompson, 91-year-old Tyner physician, died June 29 in New Carlisle.

Graduated from the Medical College of Indiana in 1905, Dr. Thompson served two years as president of the Marshall County Medical Society and as a trustee of Indiana Central College at Indianapolis for 18 years. He began his practice in Tyner in 1907. He was a Senior Member of ISMA, member of the 50-year Club and the Marshall County Medical Society. ◄

New Drug Book

In the short span of one month since its release, orders for more than 3,000 copies of the AMA's new book—*Drug Dependence: A Guide For Physicians*—have been filled.

The *Guide*, developed by the American Medical Association's Council on Mental Health and its Committee on Alcoholism and Drug Dependence, is a 186-page paperback dealing with drug abuse and dependence. Copies may be obtained at the following prices: $1.00 per copy in the U.S., U.S. Possessions, Canada and Mexico: $.50 to medical students, hospital interns and residents in the above-mentioned areas; and $1.50 in all other countries. State and county medical societies also are eligible for a 50% price reduction.

Orders should be coded "OP-233," accompanied by payment and directed to the AMA's Order Department, 535 North Dearborn Street, Chicago, Illinois 60610.

Association News

BOARD OF TRUSTEES

March 26, 1969

The Board of Trustees convened at :00 A.M. in the Chicago Room of the almer House Hotel, Chicago, Illinois, with r. Donald R. Taylor, chairman, presiding. oll call showed the following in attendnce:

District Trustee

1. Gilbert M. Wilhelmus, Evansville Present
2. Joe Dukes, Dugger Present
3. Donald M. Kerr, Bedford Present
4. Robert M. Reid, Columbus Present
5. Wilbert McIntosh, Riley Present
6. Stephen D. Smith, Knightstown Present
7. James H. Gosman, Indianapolis Absent
8. Donald R. Taylor, Muncie Present
9. Peter R. Petrich, Attica Present
10. Vincent J. Santare, Munster Present
11. Lowell J. Hillis, Logansport Present
12. William R. Clark, Fort Wayne Absent
13. Otis R. Bowen, Bremen Absent

District Alternate

2. Betty Dukes, Dugger Present
12. Frederic L. Schoen, Fort Wayne Present

Officers:

Patrick J. V. Corcoran, Evansville, president Present

Lowell H. Steen, Hammond, president-elect Present

Lester H. Hoyt, Indianapolis, treasurer Absent

Malcolm O. Scamahorn, Pittsboro, assistant treasurer Present

Frank B. Ramsey, Indianapolis, Editor, The Journal Absent

Executive Committee:

Ralph V. Everly, Indianapolis, chairman Present

Burton E. Kintner, Elkhart, member Present

Guest:

Gary Miller

Staff:

Robert J. Amick, field secretary
Howard Grindstaff, field secretary
K. W. Bush, administrative assistant
James A. Waggener, executive secretary

On motion duly made and seconded, the minutes of the meetings held January 11 and 12 were adopted as written.

The chairman announced that the meeting would adjourn promptly at 12 o'clock in order that the Board members might be at the AMA Headquarters building by one o'clock to participate in the public speaking course which would be given by the AMA.

The chairman also announced that the president had scheduled a meeting of county medical society officers to be held on April 12-13 at the Holiday Airport Inn in Indianapolis and urged the members of the Board to attend this meeting.

Reports of Members of the Board of Trustees

First District: Dr. Wilhelmus requested remission of dues for a member from his district. He moved approval and it was adopted.

Second District: Dr. Dukes announced that the Second District meeting would be held May 22nd in Sullivan, Indiana.

Third District: Dr. Kerr announced their district meeting would be held April 2nd at the Robert E. Lee Motor Inn in New Albany. He pointed out that they had planned an unusual program which would be in two portions—one was on "Sexual Information for Younger Children" and the other on "Human Sexual Response."

Fourth District: Dr. Reid announced their district meeting would be held in Batesville on May 14th.

Dr. Reid commented further that a survey had been under way in his district concerning a coronary care plan and that the result of the survey was that their community is not yet ready for this type of program.

He further reported they have elected to establish a comprehensive industrial program involving four major industries. He informed the Board that several had asked to receive a copy of the plan but this was under a private contract of their regional comprehensive health plan group and even the county society had not been able to obtain a copy of the report. Therefore, he doubted that it would be available in the very near future.

Fifth District: Dr. McIntosh reported their district meeting was planned for the last Wednesday in May.

Sixth District: Dr. Smith announced their district meeting would be held on May 1st at the Richmond Country Club and the subject for discussion would be coronary care units and pulmonary care units.

Seventh District: No report.

Eighth District: Dr. Taylor announced that the Eighth District meeting would be held at the Delaware Country Club in Muncie on June 11th.

Ninth District: Dr. Petrich announced their district meeting would be held at the Lafayette Country Club on May 22nd.

Tenth District: Dr. Santare called attention to the fact that their meeting had been changed to April 8th and would be held at the Red Lantern Inn in Chesterton.

He also reported they had a member who had retired from practice and requested that he be exempt from dues. Apparently a misunderstanding has developed inasmuch as the physician involved has retired but the payment of dues creates no financial hardship and he is not 70 years of age so as to qualify for senior membership. This was discussed by several of the trustees and no action was taken.

Dr. Santare also reported on the dissatisfaction of a physician in his county society on correspondence being sent to patients from the CHAMPUS Department. This was discussed by the president and the executive secretary and it was felt the situation might have been resolved.

Eleventh District: Dr. Hillis reported their meeting will be held in the fall, the third Monday in September.

Twelfth District: Dr. Schoen reported that the district meeting date had been changed to May 21st and would be held in Fort Wayne.

Thirteenth District: No report.

The chairman announced that we had three letters from the Thirteenth District requesting remission of dues for three physicians in the district. It was called to the attention of the chairman that the Board rule was that they do not act on remission of dues in the absence of a trustee. The chairman announced that this matter would lay on the table until the next meeting of the Board.

Reports of Officers

DR. PATRICK J. V. CORCORAN, president: Thank you, Mr. Chairman. I have a number of things on which I will try to speak extemporaneously in order to give you background. First of all I exercised the privilege given me by the Board to appoint an Advisory Committee on Health Care. As you recall, I asked for this at the August, 1968 meeting. It has taken a good deal of time to select a committee and to prepare the letters that have gone out. We do not know to what degree these appointments will be accepted and I prefer not to divulge the identity of those to whom they have been offered until we know who accepts or rejects. I have discussed this project at some length with several of you and realize that there is not unanimous enthusiasm for it. However,

Dr. Wilbur, president of the AMA, encouraged me in this. The committee is set up to advise me, in the hope that it might enable me to make recommendations and initiate policies or programs to recommend to the association. I do not want to be overly hopeful; I have stipulated that this is to last through my term only. I want you to be aware of it and will keep you informed of what occurs. If it turns out well, and I really believe it will, the association stands to gain a great deal and we will all share the credit. If it does not turn out very well, then I will assume the responsibility. I believe I should suggest an agenda for the committee. I think it very important that I have your recommendation or ideas regarding matters that we can pass on to the committee for consideration. I intend to point out to them that we are pretty well aware of our problems, but we are looking for means of dealing with them and for solutions. This is a lay committee, exclusively. It is patterned after the AMA committee. While we are here in Chicago, I hope to learn something of what they have done and what their format is. Interestingly enough, I propose to assure our committee that we will not make public their identity unless they are prepared to authorize it, thereby reassuring them that they are not to be used as a front or as a public relations ploy.

The president discussed the increasing demands on the officers' time and means of making this feasible for busy practitioners who may not yet be financially able to bear the burden. He commended the competence of the Headquarters Staff and recommended consideration of establishing the position of executive vice president, similar to that in certain other state associations. He recommended involvement in ISMA activities by both the president-elect and the immediate past president, as much as possible. He urged participation by all officers in the upcoming Conference of Medical Society Officers in Indianapolis. He reported attending, with the president-elect, two meetings in Chicago in February and in March, of the forum on standards, sponsored by the Joint Commission on Accreditation of Hospitals and his impression that the AMA commissioners had done a good job of informing the state associations of the proposed standards. He recommended formulating a resolution commending the AMA commissioners, to be submitted at the July meeting in New York. He reported on negotiations between the executive committees of the Indiana Hospital Association and of ISMA for a conference of hospital chiefs of staff, administrators, and members of the governing boards, tentatively to be held in September. He reported on his efforts to persuade physicians residing in the state who are not members, to join ISMA.

DR. LOWELL H. STEEN, president-elect: Thank you, Mr. Chairman. I would like to call to your attention a number of documents, several of which you may have read. Most have been distributed to you.

1. *The Report of the Stoner Commission.* The Legislature did not see fit to follow the recommendations of the Stoner Commission, but I thought this was an excellent report and I believe the members of this Board should be aware of their recommendations, particularly the recommendations that apply to medical education in Indiana.

2. *Report of the AMA Management Survey.* This document is the preliminary report of Cresups, McCormick and Paget relative to the AMA and their recommendations for change in the make-up of the Board of Trustees and the duties of the executive vice-president.

3. *HEW Study on Chiropractic.* This is a comparative study of chiropractic that was authorized and written by the Department of HEW in response to a request that payments for chiropractic services be incorporated in Medicare and Medicaid. This is an excellent and compendious document concerning all phases of chiropractic. I believe you should all be cognizant of the material contained in this report.

4. *An article from a recent issue of Business Week.* This article is again somewhat critical of the medical profession, speaking about the escalation of costs in the delivery of medical services. Answers should be provided to these allegations in the national press.

5. *Report on the Fourth National Assembly of the Student Health Organization.* This is a report that was reprinted from the *Ohio State Medical Journal* concerning Dr. Schreiber's observations on the Fourth National Assembly of the Student Health Organization. I believe this would be a worthwhile abstract to incorporate in our *Journal,* and I wish you would all read this because if you have never before believed that there are outside agitators working in the Student Health Organization, this will open your eyes wide. This emphasizes that we should continue our support of SAMA and continue, by gentle persuasion, to keep SAMA from getting involved in this organization which I consider very destructive in purpose.

6. *Another cost analysis published by the Ohio State Medical Association.* This socio-economic newsletter, published regularly by the Ohio State Medical Association, has attacked the problem of increasing costs, documented with statements from a variety of sources, making them available not only to their membership, but, I presume, also to the news media. I should like to suggest that we function in a somewhat similar fashion. I believe these are important areas in which we can be of benefit to our membership, and in which we can increase our involvement in areas of significant concern to us.

A number of recent events again reinforced the necessity for a spokesman for medicine. Some of the items I have just commended to your reading particularly reinforce this opinion. I think this is particularly true in Indiana as well as for the AMA. We have talked about this repeatedly, and I think the time has come for us to move! We should attempt to develop a mechanism whereby criticism directed at the profession can be answered forthrightly and promptly. The most recent example of this, in my opinion, is the terrible article in *Time* magazine that contained a number of half truths. It also contained a number of falsehoods and it contained some truthful material, some of which when taken out of context puts the medical profession in a very bad light. Anything we do in relation to public information should be done with scrupulous honesty because otherwise we will provide a very long limb to crawl out on which can then be sawed off. An example of truthfulness is a recent AMA testimony before a Senate committee in which the statement I will quote to you was made. This statement is abstracted from the AMA Washington Office weekly press release to the profession and to the newspapers.

> "Obviously, physicians could not and do not rely upon drug advertisements as their principal source of information. The drug advertisements often provide an important step in the process through which physicians become educated in the therapeutic value and risks of new drugs and a wider variety of useful drugs. Drug advertising alerts and stimulates the physician's interest in new drugs as they become available. It also serves to remind him of the broad spectrum of useful, time-proven drugs . . . .
>
> "No other advertising provides as much complete and objective information."

I don't think this sort of statement should be put out because it is not truthful and not accurate. We place ourselves in inappropriate posture when we indulge in the same sort of statements of half truth as the opposition uses.

I recently re-read a book that I read about 25 years ago—"The Horse and Buggy Doctor" by A. E. Hertzler, M.D. Dr. Hertz-

as a prairie physician in Kansas and
ly you have read his book. As I was
ng it I thought about the comments
ld make about the Joint Commission
creditation, so I have excerpted a few
raphs I would like to read to you to
te the pertinence of his comments
. These comments were written prior
38 when this book was published:

"untry hospitals have suffered much
rance from the various inspections to
t they have been exposed in recent
. These self-appointed 'slummers,' a
s Chicagoiensis, species of pestis pesti-
s, have sought to make us all accept
deas of large opulent centers where
dant wealth can compensate for
ed economy in both structure and
tenance. No thought is given to deter-
how or if the increased expenses they
us to incur would reflect to the ad-
ge or disadvantage of our patients.
an annoyance only, because no one
any attention to their recommenda-
and their refusal to recognize us is
ly ignored by the patronizing public.
he inspectors, so far as my observa-
goes, are, without exception, men who
nothing about the operation of hos-
s, either economically or professionally,
whether they are amusing or annoying
nds largely on the state of one's mind.
instance, some years ago we had just
in a new x-ray machine of the latest
n. The inspector reported that our
pment was inadequate. The chief
dardizer' wrote us that we must put
new machine. I wrote the company
had put in the machine, in a feigned
usiastically angry tone. The president
his company wrote the chief stand-
zer and told him a lot and sent me a
of the letter. This was in conformity
my general rule not to do anything
n I can get someone else to do it as
. Since then, inspectors have pro-
nced us Grade A, just as they brand
and cheese.

n the hospital field, standardization has
ght to compel us, of the typical prairie
es, to adopt the ideas of the more
lthy areas. The extravagant architecture
rally has resulted in vastly increased
s of hospital care, which in recent
's has so vastly concerned those who
e brought it on themselves. They should
e thought of that before they started
r building program. If one lives in a
ace when he is well naturally he feels
he must be sick in one. Those of the
mon herd who think marble is used
for gravestones do not miss it when
go to a hospital.

It all depends on the viewpoint. If a
of the presidents of automobile indus-
s manufacturing the higher-priced cars were asked to 'standardize' an automobile it is conceivable that they would demand that a standard machine should weigh at least two tons and a half and that everything else be in proportion, including a radio. All other cars thereby being automatically branded as inferior and undesirable. This done, everybody would sit on his haunches and wail about the high cost of transportation, and wonder why. A Grade A automobile is one that provides transportation to where you are going. A Grade A hospital is one that provides adequate care of you when you are sick. Cost is only an incidental and not a determining factor. Those who can afford luxuries certainly are at liberty to indulge themselves, be it in automobiles or hospitals, but those of us unable to afford such luxuries should be allowed to go our simpler way. The Model T and the small country hospital served their day and generation well, and it is a question if their passing did not occur all too soon.

"Why can't the standardizers leave us alone? If we are satisfied with our simpler institutions it is our affair. Being impecunious and dumb causes us no pain, certainly not so much pain as those who come about telling us that we are underprivileged. Their tears are uncalled for and unappreciated.

"In another direction the standardization of hospitals has lead to a misconception. It has not been pointed out that grading is based wholly on physical equipment. Naturally, those who do not know better are led to believe that the professional work done in Grade A hospitals also is superior. True, most high-class hospitals give a general supervision over the professional service rendered the patient. The standardizers have become much more liberal in recent years, I am pleased to note, but at best the essential factor in a hospital cannot be standardized; namely, the professional services rendered, the spirit of the hospital."

As Dr. Corcoran alluded, the meeting in Chicago was, I think, beneficial. I don't share his pessimism about failure of the commissioners to either be sympathetic or to be moved by what we say. I gained the impression that they listened with great intentness and I think there will be rapid, significant changes in the new proposed standards. If they follow the changes recommended by the physicians representing various state medical associations, this document will become much clearer and it will eliminate much of the confusion that has existed previously.

I would say that an inspection of a hospital for accreditation can be an unpleasant experience. It can be an experience that is not particularly complimentary; yet, it depends largely upon the quality of the examiner, his thoroughness, his attention to detail, or his sympathetic ear. It is unfortunate that all of these gentlemen are not high caliber, tremendously dedicated gentlemen. However, the manner in which they select these people, the availability of manpower, and the salary they can pay are the determining factors. In an effort to bring into focus some of the things that are important to those of us who practice in small community hospitals and in hospitals that do not have house staffs, and in some instances hospitals that do not have a full complement of specialty-trained physicians, I believe it is necessary to motivate the commissioners with some force. It was with this in mind that I prepared this first resolution that the AMA House of Delegates select only commissioners who are practicing physicians. Furthermore, these practicing physicians must be actively engaged in the practice of medicine at the time of their selection. As you review the makeup of the individuals representing the AMA on the joint commission, it appears to me that if the average age of those individuals was lowered a bit, and if some of those individuals who now occupy professorial status and those who are full time administrators were replaced with individuals like you, and you, and you, sitting around the table, the Joint Commission on Accreditation would be a different animal. This, in turn, might stimulate our brethren in the College of Physicians and the College of Surgeons to give some thought to individuals who practice their particular specialty rather than academicians.

The second resolution has to deal with taking proper cognizance of the position of the hospital based upon its size, composition of its staff, location, and other significant factors. If an examiner were to literally apply the standards for accreditation for a hospital say in Bedford, it might never pass. On the other hand, I am sure that many people walk out of that hospital better than when they went in, every day of the year. The point is that the inspectors don't recognize this. Therefore, we must contrive a mechanism by which this is built into the standards. It is with this purpose that I wrote this resolution. If we could gradually train these examiners to apply the standards prudently, based upon the mission of the hospital, much of the hostility and criticism of the JCAH would be eliminated. If someone can think of a better way to get them to accomplish discriminating judgment, I am in favor of it, but until a better idea is available, I propose in this resolution that three classifications of hospitals be devised with consideration given to some of the factors just

mentioned, yet, in each instance, the accreditation would be co-equal with institutions having more diverse services and more sophisticated technical equipment.

Lastly, I would like to talk to you about something that is very dear to my heart. I have discussed this at length with Dr. Corcoran and he has permitted me to present this to you. This project looks forward to next year when I will be president, and it is something that will take considerable lead time; something that is going to take some money and effort in attempting to involve other organizations so as to make use of their talents and their money, also. Our president has previously spoken eloquently on the subject of the duties of the state medical association at which time he pointed out our function as a trade association or a guild; our educational function; our function in socio-economics; our responsibilities to the public and to our professional heirs. I would suggest that we as physicians-teachers have a professional responsibility and a civic responsibility to youth. It is about youth that I am thinking in this particular project. I stole this idea in toto from the Wisconsin State Medical Association and I think it is an excellent idea. I am extremely enthusiastic about this! The State Medical Society of Wisconsin last year, as a pilot program, invited all of the junior and senior students from all of the high schools in the state of Wisconsin to Madison for four days. They subsidized part of the meals while the students were there and they provided a program for them. They delved into every aspect of human life and interpersonal relationships in human behavior. I will read to you some of the subjects, and they have some clever, catchy titles. They talked about "Project Hope"; "Should You Keep Off (Or On) the Grass" (marihuana and its health aspects); "Sex and the Teenager" (VD, sexuality, promiscuity and unwed parents); "An Interview with Health Experts"; "A Dialogue with Wisconsin's Leadership in the Health Profession:—they discussed alcohol, automobile licensure, what to do in case of an emergency, antibiotics and fad diets ("Nutritional Sense and Nonsense" was the title); "Call the Fuzz—I was Taken" (quackery and health care); "How to Kick the Habit —Two Teenagers Who Did"; "Are Sideburns Dangerous" (health hazards of hippy living); etc.

I am sure we could structure a similar program. I think four days is too long but we need at least two days of intensive activity. We could make use of people from the Indiana State Police, Indiana Dental Association, sociologists, psychologists, educators, staff from the State Board of Health, and we could involve virtually every segment of society in the state of Indiana to educate these high school juniors and seniors on timely topics of interest to them. We might start out with a less grandiose program than Wisconsin had and we might limit it to only high school seniors. I think this would be a wonderful program for ISMA to undertake, not only for the PR we would get from it, but I believe it is our responsibility to youth and I think we would have a lot of fun doing it. I don't think it would have to cost us $25,000 or $30,000, but I will say that if it did I would much rather see us spend $25,000 or $30,000 this way than in some of the ill-conceived programs that we have spent money on through the years.

Therefore, I ask your permission to proceed with the planning of this event. I should like to ask that you authorize President Corcoran to appoint an ad hoc committee to begin work with the staff because this will take much advance planning, extensive planning, and accurate planning in order to carry this program off successfully. The Wisconsin State Medical Association got reams and reams of publicity in every newspaper in the state of Wisconsin about this event. They asked for a critique from the students afterward, and I should like to propose that we incorporate a teenage panel to participate in the program, which Wisconsin did not do. I am extremely enthusiastic about this program and I kindly request that you give approval to this project in its entirety, in principle, at this time. I recognize that after some of the planning has occurred we will have to come back to you for the funding, but I would hope that we can get some preliminary estimates during the early planning so that you might more accurately budget for this event. Thank you very much!

The Board then discussed the president-elect's comments concerning Health Week. **On motion duly made and seconded, the Board authorized the president to establish an ad hoc committee to undertake planning for this event, and then to return to the Board with further suggestions. The motion was then discussed by several, put to vote and carried.**

The chairman then presented the resolutions to be sent to the AMA as requested by Doctor Steen, the first being the resolution on *Classification of Hospitals.*

"Whereas, since the founding of the Joint Commission on the Accreditation of Hospitals there has been one standard of performance for all hospitals, and,

"Whereas, these standards have been written to upgrade the character and quality of the hospital medical practice in all communities regardless of size, a

"Whereas, these standards and applicable administrative regulations not apply equally to hospitals of all but appear to be written with unive teaching centers and large metropo hospitals having a house staff as intent, and,

"Whereas, the largest number of tients are cared for in hospitals havin house staff and in hospitals of small in isolated communities,

"Now, Therefore, Be it Resolved, the commissioners of the Joint Commi on Accrediation of Hospitals be manc by this House of Delegates to set u least three categories of hospitals fo creditation, all assuring the highest qu of medical care for patients and each i own right with co-equal accreditation with at least three sets of standards the following classes of hospitals:

"A. University medical center hosp and large metropolitan hospitals ha either a university affiliation and/c house staff in continuous attendance.

"B. Large hospitals in major popul aggregations with a large and m disciplined staff but having no regu appointed resident house staff.

"C. Hospitals of smaller size in isol communities and small towns where medical disciplines are not covered where no house staff exists."

The motion was duly made seconded to adopt the resolution.

DR. HILLIS then discussed the re tion in detail relating some of the periences he has had and some of comments of his society. In a discussio others, Doctor Steen was asked to ex his thinking on this resolution.

DR. STEEN stated: "I would think in Dr. Dukes's community where he his good wife are the only two physic he shouldn't have to be burdened wi lot of paperwork which contributes ing to the quality of medical care. I do believe the volume of record keeping flects the quality of care nor can adequately assess the quality of care a record. What I was thinking about attempting to get these examiners to to your hospital and say, 'Boy, these fel are doing a good job. They're taking of a lot of people. They're getting well. They're not writing this unive type history that they were taught twenty years ago, but that doesn't they are not doing a good job.' standards are not applied equally in areas. What I feel we need to do i cut down the standards a little bit so accreditation can be achieved more e by institutions without working a hard

he medical staff and yet continue to ade the quality of care given."

urther discussion was had by sev- and a motion to adopt for send- to the AMA was put to vote and ied.

R. STEEN: Now we go to the second lution, the one on Joint Commission Accreditation.

Whereas, the Joint Commission on Ac- itation has representatives from the erican Medical Association, the Ameri- College of Physicians, the American ege of Surgeons, the American Hos- l Association, the American Nursing ue Association, and the American As- ation of Homes for the Aging, and,

Whereas, the majority of commis- ers are physicians but are not under direction of the House of Delegates of American Medical Association, and,

Whereas, the American Medical As- ation represents all of the physicians the United States of America, and,

Whereas, most of the health care de- red in the United States continues to delivered by the private practicing phy- an working in his own community, and,

Whereas, in the past the commissioners the Joint Commission on Accreditation e represented predominantly disciplines er than the private practicing physician,

Now, Therefore, Be it Resolved, that einafter all American Medical Associ- on appointees to the Joint Committee on creditation shall be at the time of their ointment private practicing physicians ively engaged in the private practice of dicine at the time of their appointment."

This resolution was discussed for rification and the motion to adopt r sending to the AMA was put to vote d carried.

DR. M. O. SCAMAHORN, assistant asurer, made the report in the absence the treasurer and called attention to the idends which had accumulated in the hnson fund and pointed out he felt the port was self-explanatory. **The chairman nounced the treasurer's report would adopted unless there was some ob- ction. There being none, the report is adopted.**

atters Referred to the Board y the Executive Committee

Legal Fees: The chairman announced at sometime ago a change was made in e method of reimbursement for legal unsel based on an hourly fee schedule ther than a retainer basis and he would ke to report that the charge for the month February was $341.77 and for March e bill was $520.00.

The Executive Committee, at its meeting last night, discussed the use of association legal counsel by component county societies and the committee felt that if a county society communicated with the state's attorney on a problem peculiar to that county but had no pertinence to any other part of the state, the county society should absorb the cost of consultation with the attorneys. On the other hand, if the issue involved is an issue which has widespread applicability to other areas of the state or the entire state as a matter of legal principle, then the state association should absorb the cost of that consultation and the Executive Committee will review these and make the determination as to the applicability, statewide or locally.

The second matter—the president has already alluded to this, that the title of our executive secretary be changed to executive vice-president of the organization, which you understand will require a change in the Bylaws. **This matter was discussed by several and on motion duly made and seconded, the motion was tabled.**

The third item—the trustee from the seventh district, Dr. James Gosman, is a candidate for election to the I.U. Board of Trustees. The Executive Committee recommends that the association endorse Dr. Gosman's candidacy. **Motion was duly made and seconded, put to vote and carried favoring the endorsement of Dr. Gosman's candidacy.**

The fourth item—Mr. Chairman, I would like to ask Dr. Steen if he would care to go over briefly the question of a dues increase which was discussed by the Executive Committee.

DR. STEEN: It is a very difficult thing for any officer to sell a rather large dues increase. In the past the dues increases have been in the magnitude of $20-$25 at a time. I know one state medical association raised their dues $125.00 in one whack. Therefore, I think the Board should give careful consideration to our long range policies, our increasing expenditures, and the increasing areas in which the state medical association is involving itself and I think to have a dynamic organization we must involve ourselves in new activities, rid ourselves of the old ones that are no longer valid and be an active, alive organization that does something constructive rather than remain a debating society. To do these things requires money and we must look forward to the time when we will most assuredly have to have an increase in dues. One of these days it is going to come upon us that it is a fact of life that we are going to have to have $25.00 more per member. Therefore, I should like to have you consider a graded increase over a period of several years and the Board will have to decide when we are to start it and the exact amount. I was thinking in terms of maybe a $5.00 increase in the fall. Therefore, the Executive Committee felt that we ought to consider an escalated rise over a period of time rather than until we need a lot of money all at once.

Item 5—The Executive Committee discussed the question of new members coming into the organization being requested to contribute $50 to the building fund. As you remember, the original action of the House of Delegates was to require new members coming in for the first time to contribute $50 to the building fund. The House later rescinded this requirement. Now we have approximately $23,000 which has been loaned to us by members of this organization for the construction of our building. This money may be recalled or it may not be—no one knows—but we felt in the Executive Committee that we could set up a payment type basis in which the $50 could be spread over say a ten-year-period to develop a fund to retire this $23,000 obligation, as the need arises, and also to develop a fund for necessary major repairs and possible expansion of our present facilities.

The chairman announced that he would commit these two recommendations from the Executive Committee to Dr. Wilhelmus' Committee on Fiscal Matters so that something might be included in the Board report at the House of Delegates this fall.

Item 6—The chairman of the Executive Committee then asked Dr. Corcoran to discuss the action of the Executive Committee concerning the use of the immediate past-president as a part of the delegation to the AMA meetings at ISMA expense. The president stated that the immediate past-president was knowledgeable and had made a lot of contacts in AMA circles and he felt would be a valuable addition to the delegation attending the AMA meetings.

On motion duly made by Dr. Schoen and seconded by Dr. Wilhelmus, it was moved that the immediate past-president attend the AMA meetings at the expense of the ISMA and in addition that a change in the Constitution be considered to make the immediate past-president an ex officio member of the Board. The motion was discussed, put to vote and carried.

Item 7—The president commented on the method of election of trustees and Blue Shield Board members by district medical societies, pointing out that Dr. Steen and he felt that there should be some consideration given to the use of a mail ballot of all members which would have

the effect of getting more members involved and possibly result in better officers at all levels of the state association. No action was taken on this recommendation.

The president then pointed out that the executive secretary had been requested to obtain some information concerning the exchange of our long term bonds for investments producing a better return. A report from Mr. Seet, trust officer of the Indiana National Bank, was read to the Board in which he pointed out an exchange might be made for some corporate bonds which might be advisable and beneficial to the association. This was discussed in great detail by several members of the Board.

Dr. Wilhelmus moved that the Executive Committee and the trustees be empowered to handle this to the best advantage of the association. The motion was duly made, seconded, put to vote and carried.

Item 8—The next item was the question of placards to be purchased by the Commission on Voluntary Health Agencies. The question had been raised about the distribution of placards by the Commission on Voluntary Health Agencies and the Executive Committee felt this should be referred to the Board for final action.

The chairman announced he would like to have Dr. Booher available for discussion of this matter and, therefore, the matter would be deferred until a later meeting.

Report of Board of Trustees Committees

1. *Board Liaison Committee with Blue Shield:* DR. KERR—I heard a letter was written by one of the members which was to be referred to my committee but as yet I have not seen the letter.

Trustee from Eleventh District: It seems to me that at the last trustee meeting Mr. Kilborn got up in front of this Board and said that in Indiana, although the federal actuaries had recommended an increase in Medicare Part B rates, that Indiana would stay on the 98 percentile of payment. Recently, sitting on a pay review committee in White County, we find that Medicare is no longer paying at the same level that it had been paying previously. We had incidents in which the pay for certain procedures were drastically cut and I would like to ask the committee to investigate this matter further. We were assured by Mr. Kilborn that there would be no decrease in fees and that there would be a holding at previous fees. Now they apparently have gone into decreasing the fee payment to physicians.

DR. KERR: I would like this to be sent to me in some organized form and should any other trustee have other information, I would appreciate it being communicated to my committee.

2. *Board Liaison Committee with Blue Cross:* DR. TAYLOR—I have no formal report at this time. Blue Cross has started construction on their new building and they had a large group there for ground breaking ceremonies, including the Governor and other dignitaries.

3. *Board Committee on Medical Education and Liaison with I.U. School of Medicine:* DR. PETRICH—No report.

4. *Board Committee of Business Consultants for the Journal:* DR. DUKES—No report.

5. *Board Committee on Governmental Medical Programs:* DR. McINTOSH—I would like to introduce Gary Miller, who is a helper with Hank Kiszla, the men who have been loaned to this committee by Blue Shield to work on the Comprehensive Health Planning Program. These fellows have been very, very busy and I am really proud of the results which we have accomplished in two months. Everything, I believe, has been going pretty good. I think that one thing we should work out is better communications between the headquarters office and these men. I am hopeful that in the near future a meeting might be held to discuss these areas of communication.

This report was discussed, with several discussing their local planning operations, and the lack of the association receiving its grant for furthering the activities in the planning field.

DR. McINTOSH commented it was his understanding that the Governor's task force would consider the application and recognition of some of the community health planning organizations at their meeting scheduled for April 2nd.

DR. CORCORAN: Before we get off the subject, I would like to have some clarification of policy and I don't want to disinter matters that have gone on in the past but I got the distinct, and I think, emphatic message that following the initial adoption by the Board of this technique in dealing with Comprehensive Health Planning that the president and president-elect, by inference, and the executive secretary, as well as the headquarters staff, were to be divorced from this activity. I made the point with Mr. Waggener that we should stay out of this. I have had inquiries too and I have told them this is not a function of the headquarters staff or the officers and, by officers, I mean the president and the president-elect and I gather this is still the situation. I just want to be sure where we stand as a matter of record and management technique. I think the president, president-elect, and the staff should [illegible] everything that is going on. I don't [illegible] this activity should be sitting out [illegible] entirely by itself. All administrative [illegible] tions ought to go through the headqua[illegible] office. I think the Board should ma[illegible] very clear because I don't think you [illegible] have a dichotomy. As I understand it, [illegible] project is not under the direction o[illegible] executive secretary or the president. [illegible] matter was further discussed in grea[illegible] tail with an exchange of views being [illegible] between the officers and the Board.

6. *The Board Committee on F[illegible] Matters:* No report.

7. *Board Committee on Emergency M[illegible] cal Services:* DR. HILLIS reported [illegible] would bring the Board up to date a[illegible] what the experiences in Indiana have [illegible] as far as emergency medical services [illegible] concerned. This is operated under the I[illegible] way Safety Plan drafted in 1966. A yea[illegible] almost a year ago, the government [illegible] pointed a Commission on Emergency M[illegible] cal Services. The federal government [illegible] for the development of a plan by the st[illegible] under threat of losing a portion of [illegible] funds allocated for highway use. The [illegible] ent plan was to be in by the first of M[illegible] and the meeting was to be tonight for [illegible] final acceptance of it. The work has [illegible] done and constitutes a lot of good [illegible] by a lot of individuals.

Following the action of the Hous[illegible] Delegates in October, 1968, the presi[illegible] appointed a Commission on Emerg[illegible] Medical Services. The chairman is [illegible] John Farquhar of Fort Wayne. D[illegible] Farquhar has done some outstanding [illegible] in this field and has had several pro[illegible] tive meetings. The commission has invo[illegible] itself with four of the six headings u[illegible] consideration by the Governor's com[illegible] sion. Some of the problems that [illegible] evolving are problems which have t[illegible] with rules and regulations of the Nati[illegible] Highway Safety organization. I think [illegible] ought to thank Doctor Farquhar as I t[illegible] he is making real fine progress. How[illegible] any results or any activity bringing a[illegible] a policy matter, if my understandin[illegible] correct, must come through the Boar[illegible] Trustees.

DR. SCHOEN: As long as we are th[illegible] ing along this line, and if you have t[illegible] I would like to refer to you a report [illegible] Dr. Farquhar's commission. The com[illegible] sion has been discussing highway r[illegible] markers but cannot go further wit[illegible] formal consent from the Board of Trus[illegible] The sign has been designed by the [illegible] mission for erection on highways poin[illegible] out where emergency medical services [illegible] be obtained. Dr. Farquhar is very di[illegible] pointed with the attitude of both fed[illegible]

and state highway people concerning the approval of this proposal.

Dr. Schoen moved at this time that the Board support the commission in their activities and lend their support in urging the implementation of a plan to use these signs. The motion was seconded.

Dr. Hillis discussed some of the problems in the design of the sign and there are still several hurdles to be cleared before the program can be implemented.

The motion was further discussed by several, put to vote and carried.

Dr. Schoen continued by discussing the commission's activities with a discussion of the Motorola Hear System. This is a system developed by Motorola that has been recommended by the Indiana Hospital Association and I would like to request approval from the Board of Trustees to try to push this system throughout the state as I believe this is the only available method of radio communication between hospitals, ambulances, police, etc. There is no other company producing this system which can compete with this.

Therefore, I would like to move the Board approve the commission going ahead with the Hear System. **The motion was seconded and discussed by several. A motion was made to amend the motion for approval by adding the words "or an equivalent system."**

Dr. Schoen and the second accepted the amendment. Question was called for, the motion was put to vote and carried, as amended.

Dr. Schoen continued with further comment concerning the commission's activities and discussed the efforts to implement a uniform emergency telephone number, such as "911." Dr. Schoen pointed out that a Bell system had set aside money to implement this but, unfortunately, did not want to implement this system on a non-payment basis. The commission has met with the president of Indiana Bell and Dr. Farquhar feels that if we push hard enough we will eventually get this system. Dr. Corcoran felt the Board should be apprised of this activity by the commission and I would like to have the permission of the Board to proceed in trying to implement this although it is rather doubtful that it will become effective in the very near future.

It was moved to give the commission permission to proceed. The motion was seconded and a discussion ensued concerning the fact that there are 62 small telephone companies in Indiana, not including Indiana Bell and General Telephone.

The question was called for and a motion for approval to proceed with investigation of implementation for a telephone emergency number was granted.

Chairman: We have to determine the date of our next meeting. The AMA meets July 13-17.

On a poll of the Board, the dates of June 28-29 were approved for a meeting of the Board at which time they will meet with the delegates and alternate delegates to the AMA.

Economic and Organization Matters

The Commission on Inter-Professional Relations seeks the advice and direction of the Board concerning the recent action of the AMA in Miami, December, '68, concerning osteopaths, realizing that many problems could arise in accepting osteopaths in the state medical association. It is felt that the commission should have the advice of the Board since the Board and the House of Delegates would make the final determination.

DR. KERR: I think we would be in a bad position if we attempt to oppose the national association in what it is attempting to do. Discussed by Dr. Petrich, Dr. Dukes and Dr. Scamahorn.

On motion of Dr. Petrich and a second by Dr. Kerr, it was moved that we ask the commission to contact the county societies to encourage osteopaths who may be acceptable in all regards to attend their staff and society meetings.

The motion was put to vote and carried.

On motion of Dr. Corcoran, and a second by Dr. Kerr, it was moved that the Commission on Inter-Professional Relations be authorized to recommend to the Commission on Constitution and Bylaws that they draft an appropriate amendment to our Constitution and Bylaws permitting eligible osteopaths to become members of county, state and AMA organizations, if the AMA approves such a change in their Constitution and Bylaws.

An amendment was proposed to the motion that the Inter-Professional Relations Commission should refer their report back to the Board and the Board in turn refer it to the Commission on Constitution and Bylaws, if the Board agrees. The amendment was accepted by Dr. Corcoran and Dr. Kerr.

The motion, as amended, was put to vote and carrried.

On motion of Dr. Steen and taken by consent, the Board approved the action of the Executive Committee in allocating $300 to the Commission on Public Information for the purchase of educational materials on Defense Against Quackery.

Chairman: We had a communication from the State Board of Health concerning a report on the distribution of RH (D) Immune Globulin-Human. Dr. Offutt wants approval to go ahead with this program and requests the approval of the Board of Trustees.

The motion was made, seconded, put to vote and carried to allow Dr. Offutt to proceed.

Chairman: The Commission on Inter-Professional Relations referred two matters to the Board.

The first was the possibility of getting the Indiana Bar Association to consider setting up a liaison committee with a like committee of physicians for preliminary discussion on malpractice cases.

DR. CORCORAN: I think this is already covered by the Committee on Medical-Legal matters and I wonder if this committee would not be duplicating their function.

Chairman: If it is all right then with the Board, this committee is to be informed that this matter be handled in a different manner.

The matter was taken by consent.

The next matter was the possibility of a joint committee of certified public accountants with a like group from the association and representatives of any other professional groups that are interested in liberalizing the Keogh bill and the Medical Practice Corporation Act.

The motion was made and seconded that the Commission on Inter-Professional Relations proceed with vigor to find out all they can and whether the CPA organization is interested in attempting to liberalize the Keogh Bill.

The motion was put to vote and carried.

8. *Ad Hoc Committee on Computerized Medicine:* DR. REID—I have attempted to divide this into two major areas of interest, namely "Computers and the Organized Hospital Staff" and on computers, I'll be brief. Since I last talked to you I have visited 11 different states and have spent a number of hours discussing these problems with various people and have come to some conclusions. The first conclusion is a happy one for me. On April 7th, I go to New York to finalize an arrangement for a pilot program in our region. I hope before too many months have passed to have a preliminary program on a wide scale regional application to demonstrate that this is effective. Several outstanding men have demonstrated that the computerizing of medical histories is practical on a small scale yet no one has demonstrated the wide application of this system and its use in everyday practice.

The second conclusion relates to the requirement for the effective implementation of this plan. The first and obvious one is money. Now this is a substantial commitment and I think we should take some other time to discuss some of the possible sources of that kind of money. I will say only this; that I think it could be forthcoming. As you think about this, one matter which is a meaningful one is the expenditure of time and energy on the part of talented physicians to make this program work. This has been the dilemma that has stopped IBM and many other programs from proceeding further, namely, of physicians being unwilling to devote the time necessary to carry these things out. If you feel this idea is worth proceeding with, as we develop the program, you must realize that many of you and many of the members of our state organization will be asked to give a lot of time in its development.

The third conclusion is that in order to effectively deploy such a technology you must have a controllable large market. Now the word "controllable" is objectionable, I know, but you've got to be realistic to meet these things as these things must be controlled. You must be able to predict how many display units you are going to need in a given hospital facility. Further, you must have an organization sufficiently potent to administer such a program, to carry it out, and to be able to reliably predict what is going to happen.

This brings me to the second part of the report, and that is the matter of organization of medical staffs. I would like to discuss what I think are some of the potential values of this kind of an organization. The first and most obvious application is that of medical education. I have discussed this with a group of medical education directors and they are interested and I think this would make the most logical group to direct and incorporate the whole area of medical education in this kind of statewide organization. The potential for regional organization of medical education is grouping three or four smaller hospitals together in such a way so they can merit a part-time director of medical education.

There is a practical point in this area, which is of interest to hospitals. Many of you know that certain court decisions in the last 18 months have rather clearly set the responsibility for the actions of the medical staff in the lap of the governing board of the hospital. Hospitals are quite interested and will become increasingly interested in the caliber of the medical staff. I think hospitals, if not immediately, will soon welcome some help in encouraging upgrading in their medical staff. I think, too, most physicians would appreciate this kind of help.

The matter of standards, unpopular as it is, and the matter of recertification of physicians are points which we cannot much longer ignore. I think if we don't do something about them, somebody will do it for us, and I believe it will be difficult for the ISMA to do this, although perhaps they can, but it probably would be easier for an organization based on the authority given to a hospital medical staff to carry on this kind of function. All of you who have worked in the area of Regional Planning and Comprehensive Health Planning are aware of the fact that there is a great tendency in facility planning to think in terms of satellite programs more than in the conventional sense but simply setting up central facilities with consolidation of existing peripheral facilities. I contend that this could more logically be done on the basis of professional talents rather than strictly on the basis of facilities.

In directing both the computerization and medical staff program, I would say we should take the initiative in working into these types of programs with the idea of getting as much done as we can.

You will recall that the Board approved the idea of exploring this and the committee has met since and developed a letter which might be sent to the chief of staff or to elected leaders of hospital organizations. At that time it was hoped that we could have a meeting in early April in conjunction with the County Society Officers meeting but for various reasons it was not a good idea so this meeting has been delayed.

Dr. Reid's comments were discussed by many. **On motion of Dr. Petrich and a second by Dr. Steen, the president was authorized to appoint an ad hoc committee to study use of computers, including personnel other than trustees, to cooperate with Dr. Reid for a meeting of organized chiefs of hospital staffs. The motion was put to vote and carried.**

On motion of Dr. Petrich and a second by Dr. Steen, Dr. Reid was authorized to organize a meeting of the elected chiefs of staffs of hospitals and the ISMA to finance the effort. The motion was put to vote and carried.

There being no further business, the meeting was adjourned with the Board to meet again at 6:00 P.M., Saturday, June 28, 1969. ◄

EXECUTIVE COMMITTEE

March 25, 1969

Meeting called to order at 7:00 p.m. by the chairman Dr. Ralph V. Everly in the Palmer House, Room 1550-W, Chicago, Illinois.

Present: Ralph V. Everly, M.D., chairman; Burton E. Kintner, M.D., Patrick J. Corcoran, M.D., Lowell H. Steen, M.D., Donald R. Taylor, M.D., M. O. Scamahorn, M.D., and James A. Waggener.

Membership Report

Number of members as of December 31, 1968	4,444
1969 members as of February 28, 1969:	
Full dues paying	3,472
Residents and interns	73
Board remitted	53
Senior	329
Honorary	2
Military	41
Total 1969 members as of February 28, 1969	3,970
Number of AMA members as of December 31, 1968	4,289
1969 AMA members as of February 28, 1969	3,846
Full dues paying	3,350
Exempt, but active	496
	3,846
Number who have paid state dues but not AMA dues as of February 28, 1969	122

Headquarters Office

CERTIFICATE OF APPRECIATION—The secretary presented the copy of the certificate of Appreciation and on motion of Dr. Steen and taken by consent, it was approved with minor changes.

LETTER FROM INSURANCE CARRIER—A letter from the insurance carrier concerning the placement of fire extinguishers in the headquarters building and a questionnaire from Barton, Curle and McLaren were reviewed. The purchase of 5 extinguishers @ $47.00 each was approved on motion of Drs. Steen and Taylor.

LEGAL EXPENSE—The secretary presented the statement of legal expenses for the months of February and March which were approved on motion of Drs. Steen and Taylor.

A discussion was held concerning the policy of the association paying for legal services that were solely for county benefit and it was requested that the secretary get a copy of the letter of opinion provided by legal counsel to the Lake County Medical Society.

EXPENSES FOR ATTENDANCE COUNTY SOCIETY OFFICERS CONFERENCE—The question of payment of expenses for members of the Executive Committee, Board of Trustees, and members of commissions for attendance at the Conference of County Medical Society Officers was discussed. On motion of Drs. Steen and Taylor, it was voted that the usual travel and hotel expenses, plus cost of food, be provided for members of the Executive Committee, the Board of Trustees and the commissions involved.

FINANCES OF THE ASSOCIATION—The president discussed the matter of finances of the association and stated he felt that it was not the responsibility of the president but of the Board to propose additional needs in the way of finances for expense of operation of the association.

This matter was discussed at length and on motion of Drs. Steen and Kintner, it was voted to recommend to the Board of Trustees that the Board study the recommendation of the Executive Committee that the Board propose a graduated dues increase each year of approximately $5.00 per year rather than waiting until such time as the association is sorely in need of funds and then to ask for a large increase all at once.

THE TREASURER'S REPORT was approved on motion of Drs. Taylor and Kintner.

INVESTMENTS—A letter from the Indiana National Bank Trust Department making certain proposals about the investment of bonds currently held by the association was referred to the Board on motion of Drs. Steen and Kintner.

Organization Matters

A LETTER FROM AMA inviting five representatives of the ISMA to attend their Public Affairs meeting in Washington May 17-18, with expenses paid, was reviewed. On motion of Drs. Taylor and Kintner the association list is to include Drs. Corcoran, Steen, Taylor, Neumann, and Mr. Waggener. The IMPAC organization is to be requested to defray the expenses of the two field men plus three or more additional delegates from their organization.

LETTER FROM DR. WM. CLARK—A letter from Dr. Wm. Clark, trustee from the 12th District, was read for the information of the committee.

REQUEST OF COMMISSION ON PUBLIC INFORMATION—The request of the Commission on Public Information for the purchase of kits on "Defense Against Quackery" was reviewed and on motion of Drs. Steen and Taylor, the commission is allocated $300 for this purpose.

LETTER FROM VOLUNTEERS OF AMERICA—A letter from the Volunteers of America for use of the mailing list for distributing a flyer on the Theodora House was reviewed and the use of the mailing list was approved on motion of Drs. Kintner and Taylor.

EMERGENCY ROOM PERSONNEL INFORMATION—The material which has been submitted by the Indiana Hospital Association entitled "Guidelines for the Development of Standing Orders for Emergency Room Personnel" was referred to the Commission on Emergency Medical Services on motion of Dr. Steen and taken by consent.

LETTER FROM DR. OFFUTT—A letter from the State Board of Health concerning need of medical staff people for about ten hours per month at the School for the Deaf was read for the information of the committee.

SAMA LETTER—Dr. Corcoran reviewed a letter received from SAMA reporting on their trip to the American Conference on Medical Education. Dr. Corcoran also made the statement that the group had returned $45.00 in unused funds.

REQUEST OF SAMA ORGANIZATION—The request of the SAMA organization for $500 to help defray the expenses of their delegates to their annual meeting was approved on motion of Drs. Steen and Kintner.

ARIZONA MEDICAL ASSOCIATION LETTER—A resolution of the Arizona Medical Association concerning the Food and Drug Administration was accepted as a matter of information.

U.S. CHAMBER OF COMMERCE MEMBERSHIP—Renewal of membership in the U.S. Chamber of Commerce in the amount of $50.00 was approved by consent.

MEDICARD OF AMERICA—A letter announcing the establishment of Medicard of America, Inc., was reviewed for the information of the committee.

DR. STEEN'S LETTER REGARDING BLUE SHIELD BOARD—A letter from Dr. Steen concerning Blue Shield Board membership was reviewed for the information of the committee.

LETTER RE VACANCY ON BLUE SHIELD BOARD—A letter from the president of the Allen County Medical Society concerning the nomination of a physician for the vacancy on the Blue Shield Board from the 12th District was presented to the committee.

ARTICLE ON EMERGENCY MEDICAL CARE—An article on Emergency Medical Care prepared by Dr. John S. Farquhar was reviewed by the committee and ordered studied and forwarded to the editor of *The Journal* on motion of Drs. Steen and Kintner.

COMPREHENSIVE PLANNING MATERIALS—Releases from the director of the State Comprehensive Health Planning Committee were reviewed for information of the committee.

REFERRAL FROM COMMISSION ON MEDICAL ECONOMICS AND INSUR-

ANCE—A letter referred to the Executive Committee from the Commission on Medical Economics and Insurance was referred to the Board Liaison Committee with Blue Shield on motion of Dr. Steen and taken by consent.

Convention Matters

AMA COUNCIL ON VOLUNTARY HEALTH AGENCIES—The program for the meeting of the AMA Council on Voluntary Health Agencies to be held in Indianapolis on Sunday, October 12, was reviewed for the information of the committee and it was noted that the members of the Executive Committee were invited to attend this meeting.

New Business

DR. JAMES GOSMAN CANDIDATE FOR I.U. TRUSTEE—The chairman announced that Dr. James Gosman was to be a candidate for the I.U. Board of Trustees and sought the endorsement of the Indiana State Medical Association in his campaign. Such endorsement and best wishes for his success were extended by motion of Drs. Corcoran and Scamahorn.

DR. RALPH V. EVERLY—Dr. Ralph V. Everly expressed his appreciation to the committee for their remembrances in his recent bereavement.

NATIONAL MEDICAL SCHOOL BILL—Dr. Corcoran discussed the bill before the Congress in which the government had proposed to establish a National Medical School. It was noted that the AMA had voted to oppose this issue at both the San Francisco and Miami meetings and that this should be the policy of the Indiana State Medical Association.

MEETING WITH CHIEFS OF HOSPITAL STAFFS—The president then discussed his desire to establish a meeting of the elected chiefs of staff of hospitals along with the hospital administrator or a member of the board similar to the program which had been carried out successfully in other states. On motion of Drs. Corcoran and Steen, it was voted that the Board of Trustees be requested to authorize the Executive Committee of ISMA to work out such a program with the Executive Committee of the Indiana Hospital Association.

REIMBURSEMENT OF PHYSICIANS—The president then discussed the matter of reimbursement of physicians under the various federal programs and by consent it was agreed that this matter be placed on the next agenda of the Executive Committee.

ROLE OF PAST PRESIDENT—Dr. Corcoran then raised the question concerning the role of the immediate past president as far as his activities were concerned with the delegation in the annual and clinical meeting of the AMA following his term as president of the association. This matter was thoroughly discussed and on motion of Drs. Steen and Kintner, it was voted to recommend to the Board of Trustees that the immediate past president be made a part of the official delegation to the clinical and annual meetings of the AMA for the year following his term as president and that his expenses be borne by the association.

ELECTION OF TRUSTEES—The subject was then discussed concerning the election of trustees and others at the district level and on motion of Drs. Steen and Taylor, the committee voted to recommend to the Board of Trustees that they consider recommending an amendment to the state Constitution and Bylaws to provide that all elections held at the county society and district society levels be done by a mail ballot to each member of the county society and the district society. It was further suggested that legal opinion be obtained to determine if this could be done.

LETTER FROM A. H. ROBINS COMPANY—A letter from the A. H. Robins Company offering to supply a physician award program in which the association would make an award to a physician for his community service was accepted on motion of Drs. Steen and Kintner.

AGREEMENT FOR INSURANCE—An agreement for the offer of insurance coverage to physicians who could not qualify for physical reasons under the present program was reviewed and on motion of Drs. Scamahorn and Kintner, the president was authorized to sign the contractual agreement provided it met with the approval of the Commission on Medical Economics and Insurance.

The Journal

SMJAB NEWS LETTER—A News Letter from the State Medical Journal Advertising Bureau was reviewed for the information of the committee.

Future Meetings

THE AMA 2ND ANNUAL CONFERENCE ON NURSING to be held in Chicago April 11-12; Dr. Everly is to supply a name for this meeting.

ANNUAL CONFERENCE INDIANA HEALTH CAREERS—Indianapolis April 15; Mr. Bush was authorized to attend the meeting.

AMA CONFERENCE IN INTERNATIONAL HEALTH—Chicago May 22-23; Dr. Everly will represent the association at this meeting if possible.

THE DATES OF JUNE 3, 4, and 5 [illegible] established for the annual visitation [illegible] the Indiana Congressional delegation.

There being no further business, [illegible] committee adjourned to meet again at 1[illegible] Noon Saturday, April 26, and will join [illegible] Commission on Medical Economics [illegible] Insurance for lunch.

EXECUTIVE COMMITTEE

April 26, [illegible]

Meeting called to order by the chairm[illegible] Dr. Ralph V. Everly, in the Inc[illegible] apolis Athletic Club.

Present: Ralph V. Everly, M.D., ch[illegible] man; Burton E. Kintner, M.D., Patric[illegible] V. Corcoran, M.D., Lowell H. Steen, M[illegible] Donald R. Taylor, M.D., M. O. Scamah[illegible] M.D.

Frank Ramsey, editor, *The Journal* [illegible] James A. Waggener.

Membership Report

Number of members as of December 31, 1968	4,44
1969 members as of March 31, 1969:	
Full dues paying	3,80
Residents and interns	8
Board remitted	5
Senior	32
Honorary	
Military	4
Total 1969 members as of March 31, 1969	4,31
Number of AMA members as of Dec. 31, 1969	4,28
1969 AMA members as of March 31, 1969	4,17
Full dues paying	3,664
Exempt, but active	506
	4,170
Number who have paid state dues but not AMA dues as of March 31, 1969	
ISMA Membership as of April 25, 1969	
Full dues paying	3,85
Residents	8
Board remitted	5
Senior	32
Honorary	
Military	4
Total	4,36

Headquarters Office

CERTIFICATES OF APPRECIATI[illegible] to past members of the Council, the Exe[illegible] tive Committee and AMA delegates w[illegible] presented for signature by the preside[illegible] president-elect and chairman of the Boa[illegible]

SPRINKLING SYSTEM—A propos[illegible] for installation of an automatic sprinkli[illegible] system at the headquarters office was p[illegible] sented and on motion of Drs. Steen a[illegible] Kintner, the bid of Water Systems, In[illegible] was accepted.

OTEL BILLS—The hotel bills for the ent meeting of the Board and the Execu- Committee in Chicago were given to committee for review.

REASURER'S REPORT—In the ab- e of Dr. Hoyt, the treasurer, his report presented in absentia and was accepted presented on motion of Drs. Taylor and n.

card of thanks from Dr. Hoyt for the embrance sent to him by the mem- s of the Board and the Executive Com- tee was read.

ganization Matters

ETTER FROM MR. KILBORN—A er from Mr. Kilborn, president of tual Medical Insurance, Inc., concern- the report of the Nominating Committee the Blue Shield Board was reviewed for rmation of the committee.

MINUTES, BLUE SHIELD MEMBERS ETING—Several items appearing in minutes of the members meeting of tual Medical Insurance, Inc., held rch 20 were called to the attention of committee.

ETTER FROM ALLEN COUNTY EDICAL SOCIETY—A letter from the en County Medical Society concerning esolution to be presented to the AMA use of Delegates in July was reviewed d on motion of Drs. Steen and Kintner, ies of this resolution are to be sent to Board of Trustees with the recommen- ion that they favorably approve the sentation of this resolution.

U.S. PHARMACOPEIAL CONVEN- ON—A letter from Arthur C. Degraff, D., president of the U.S. Pharmacopeial nvention, Inc., concerning the 1970 ennial meeting was reviewed for the ormation of the committee.

AMA BOARD OF TRUSTEES REPORT The report of the meeting of the AMA ard of Trustees held March 27-28 was iewed for the information of the com- ttee.

ETTER FROM JOINT COMMITTEE ATIENT CARE—A letter from the Joint mmittee for the Improvement of Patient re notifying the association their an- al contribution of $25.00 was now due s deferred and in the meantime the cretary is to make inquiry of Dr. Davis d other M.D.'s concerning the value of is committee and is to be placed on the xt agenda of the committee.

ETTER FROM DR. RIFNER—A letter m Dr. Rifner offering his resignation as member of the Regional Medical Program d from the Governor's Advisory Com- ittee on Comprehensive Health Planning as read and the resignation was accepted ith regrets on motion of Drs. Steen and rcoran.

NOTE FROM HARRISON-CRAWFORD SOCIETY—A notice from the Harrison-Crawford County Medical Society informing the association that at their meeting they had changed the name of the society to the Harrison-Crawford Medical-Dental Society, was read and on motion of Drs. Steen and Corcoran, this was tabled until further information is received.

HEALTH INSURANCE COUNCIL LETTER—A letter from the Health Insurance Council requesting the cooperation of the association in establishing a Joint Advisory Committee composed of representatives of the medical association, the Hospital Association and the insurance companies, including Blue Cross-Blue Shield, to be known as the "Hospitals-Insurance-Physicians Joint Advisory Committee" was reviewed and on motion of Drs. Corcoran and Kintner, approval was given to Indiana State Medical Association participation.

INDIANA LAW ENFORCEMENT ACADEMY LETTER—A letter from the Indiana Law Enforcement Academy requesting the endorsement of the association of a campaign for raising funds from private sources totalling $12 million to develop the Indiana Law Enforcement Academy was reviewed and on motion of Drs. Steen and Taylor, it was voted not to lend endorsement by the association inasmuch as it was felt this was not within the framework of the medical profession.

KEY FACTS—SPECIALTY FAMILY PRACTICE—A flyer setting forth key facts on the new Specialty Board of Family Practice, was reviewed for the information of the committee.

BALLOT FOR U.S. CHAMBER OF COMMERCE—A ballot for the U.S. Chamber of Commerce concerning a proposed change in their policies with respect to federal health insurance was discussed in great detail and on motion of Drs. Taylor and Kintner, it was moved that the association would vote "no" on this proposal. The motion was approved on a vote of 3 - 2 with Drs. Corcoran and Steen dissenting.

BAYH NEWSPAPER ARTICLE—A recent article in a newspaper announcing Senator Bayh's probe of medical care of military men was reviewed for the information of the committee.

AMA LETTER—A letter from the AMA setting forth the action of the AMA House of Delegates defining the terms "usual", "customary", and "reasonable" was reviewed and on motion of the chairman of the Board, copies of this information is to be distributed to the insurance industry doing business in Indiana.

ANNOUNCEMENTS-OREGON AND WEST VIRGINIA—Announcements from the Oregon and West Virginia Medical Associations concerning their candidates for re-election of the board of trustees and as vice-speaker of the House of Delegates of the AMA were reviewed for the information of the committee and the secretary is requested to send copies of this material to the Indiana delegation to the AMA.

BLUE CROSS RATE REVIEW COMMITTEE—The proposal for the re-election of the Rate Review Committee of Blue Cross was reviewed and Dr. Taylor is to discuss this with Dr. Neumann.

AMA WHITE HOUSE CONFERENCE—A letter from the AMA informing the ISMA that they had nominated Dr. Sprague H. Gardiner of Indianapolis as a delegate to the President's National Committee for the 1970 White House Conference on Children and Youth was reviewed for the information of the committee.

Convention Matters

GUEST INVITATION LIST—The invitational guest list for the annual meeting was discussed and by consent it was agreed that the same list would be issued invitations as in 1968.

ENTERTAINMENT CHARGE—The question of whether or not a charge should be made to the members for the entertainment program to be held on Thursday evening during the convention was discussed and by consent it was agreed that no charge should be made and further that tickets should be distributed to physicians for their use in inviting their patients and friends to attend this program.

ROBINS PHYSICIAN AWARD PROGRAM—A letter from the A. H. Robins Co. concerning the Physician Award Program was called to the attention of the committee and on motion of Drs. Steen and Taylor, the compilation of the rules used in Mississippi and Maryland would be used for the rules in making this award in Indiana and that the promulgation of these rules and the judging of the nominees should be in the hands of the Commission on Public Information.

New Business

LEGAL EXPENSE—The report of legal expense for the preceding month was given to the committee for their information.

R.M.P. LETTER—The president announced he was sending a letter to the headquarters office which had been signed by Dr. Davis for the Regional Medical Program and the secretary was instructed to distribute copies of this to the Executive Committee.

LETTER FROM COMMISSION ON

VOLUNTARY HEALTH AGENCIES—A request from the Commission on Voluntary Health Agencies concerning the importance of the officers of the Indiana State Medical Association attending the Regional Conference of Voluntary Health Agencies of the AMA to be held in Indianapolis on October 11-12 and that the officers should be invited to attend the annual banquet at 7:00 p.m. on the night of October 11th was read.

On motion of Drs. Steen and Taylor, a copy of this material is to be placed on the agenda for the Board of Trustees meeting on June 28-29.

LETTER FROM DR. OFFUTT—Dr. Offutt requested the approval of the committee to permit a pertinent study being conducted in Daviess County for the use of Neo-Polycin ophthalmic ointment in the eyes of newborn rather than 1% silver nitrate. On motion of Drs. Taylor and Kintner, this request is to be referred to the Board of Trustees and Dr. Offutt is to be requested to discuss this matter before the Board at its next meeting.

REQUEST OF BOARD OF HEALTH—The request of the Board of Health for distribution of RH_0 (D) Immune Globulin-Human was again referred to the committee and inasmuch as this had been previously approved, the approval was confirmed.

PROPOSED LETTER TO NON-MEMBERS—The president then reported his intention to write a letter to all non-members of the association urging them to join their county medical society and the state association and that he was asking the county societies to provide a list of non-members within their county whom they would welcome as members of their local societies.

MEDICAL-LEGAL CODE—The president discussed the Medical-Legal Code and on motion of Drs. Corcoran and Steen it was moved that this be republished in *The Journal of the Indiana State Medical Association.*

PRESIDENT-ELECT'S REPORT—The president-elect reported on his visitation to the Governor's office and witnessing the reappointment and swearing in of Dr. A. C. Offutt as secretary of the State Board of Health. He also mentioned that the Governor had approved the use of funds by the state medical board for giving the FLEX examination.

DR. KINTNER'S REQUESTS—Dr. Kintner asked if the trustees may visit meetings of the Executive Committee and he was informed "yes."

Dr. Kintner discussed a survey made sometime ago in which a report was to be given to the association and he asked for the authority to write a letter requesting such copies and permission was granted.

The Journal

PRESIDENT'S ANNUAL REPORT—Dr. Ramsey reviewed the president's report of SMJAB for the information of the committee.

Future Meetings

THE PUBLIC AFFAIRS meeting in Washington, D.C., May 17-18—the arrangements were discussed and on motion of Dr. Taylor, this is to be referred to the IMPAC Board.

AMA ANNUAL SESSION—The secretary reported on the plans and time for registration at the AMA annual sessions in New York City.

WASHINGTON TRIP—The Washington visitation with the Congressional delegation on June 3, 4, 5 was discussed and on motion of Drs. Corcoran and Steen, the Commission on Legislation is to be invited to select up to three representatives from their commission to attend this meeting.

12TH CONFERENCE PHYSICIANS & SCHOOLS—A notice of the 12th National Conference on Physicians and Schools to be held in Chicago, October 8-11, was reviewed and it was taken by consent that Dr. Santare is to be requested to represent the association.

ORGANIZATION OF COMMISSIONS—The president-elect announced that he plans to hold an organization meeting of the new commissions on Sunday, November 2nd, and that he proposed to hold the County Society Officers Conference on February 14, 1970.

There being no further business, the meeting adjourned with the next meeting to be held on the evening of June 3rd in Washington, D. C.

EXECUTIVE COMMITTEE

May 25, 1969

Meeting called to order by the chairman, Dr. Ralph V. Everly in the headquarters office, 3935 North Meridian Street, Indianapolis, Indiana.

Present: Ralph V. Everly, chairman; Patrick J. V. Corcoran, M.D., Lowell H. Steen, M.D., Donald R. Taylor, M.D., Lester H. Hoyt, M.D., and James A. Waggener.

Headquarters Office

RENEWAL OF BLUE CROSS-BLUE SHIELD COVERAGE—Renewal of the Blue Cross-Blue Shield coverage for the headquarters personnel was approved on motion of Drs. Steen and Taylor.

LETTER FROM AUXILIARY—T chairman presented a letter and a ch for $1,000 from the Woman's Auxiliary apply toward the kitchen fund. On mot of Drs. Corcoran and Taylor, the auxili is to receive a letter of appreciation their continued cooperation.

Organization Matters

JOINT COMMITTEE PATIENT CA —The request of the committee to obt an opinion concerning the Joint Com tee for the Improvement of Patient C resulted in a letter from Dr. Joe Davis a telephone call from Dr. John O. But who informed the committee that the jo committee had voted itself out of busin

COMPREHENSIVE HEALTH PLA NING ACTIVITY—The operation of C prehensive Health Planning activity discussed again at length and on mot of Drs. Steen and Taylor, the follow motion was adopted: The Executive C mittee recommends to the Board that field men who are dealing with the field Comprehensive Health Planning be signed to the headquarters office and t the Board committee, through the Boa and with the approval of the Board, m policy but the administrative control these two employees be under the dir supervision of the president and executive secretary.

HEALTH INSURANCE COUN LETTER—A letter from the HIC inquir if it might be possible for the HIPJ Committee to meet during the time of annual meeting of the state association read. Dr. Corcoran moved and it was ta by consent that the suggestion be m that the meeting be held during the t of the annual meeting.

On motion of Drs. Steen and Taylo was voted that the naming of represe tives of this committee be assigned to Commission on Medical Economics and surance with the suggestion that they n four members of their commission, plus executive secretary, to be ISMA re sentatives of this committee.

DRIVER'S EXAMINATION STA MENT—A driver's examination statem developed in the state of Alabama, wh carried a statement that the determinat of the ability of a patient to drive vested by law in their Motor Vehicle partment is to be referred to the Board Trustees, on motion of Dr. Steen a taken by consent.

CONFERENCE WITH JUDGE HAMI —The secretary reported on a confere he had had with Judge Hamill concern the suit against Blue Cross on the provis of professional services. The judge wo like the opinion of the association as whether or not he shall pursue this c

drop it. On motion of Drs. Corcoran and en, this question is referred to the Board Trustees for discussion and at the request of the chairman of the Board, Judge mill is to be invited to appear before the ard at its meeting on Saturday evening, ne 28th.

AMA CANDIDATES—Dr. Corcoran ted he would like permission to invite candidates for AMA offices to appear fore the Executive Committee and the MA delegation during the New York eeting. Permission was given by consent. There being no further business, the eeting adjourned to meet again at 3:00 m. Saturday, June 28th, 1969 in the adquarters building.

XECUTIVE COMMITTEE

June 28, 1969

Present: Patrick J. V. Corcoran, M.D., owell H. Steen, M.D., Donald R. Taylor, .D., Burton E. Kintner, M.D., Frank amsey, M.D., and James A. Waggener.

MINUTES OF THE MEETINGS held pril 26 and May 25 were approved, upon otion of Dr. Steen and seconded by Dr. aylor.

THE MEMBERSHIP REPORT as of lay 31 was reviewed and accepted as rinted, and upon motion of Dr. Steen and aken by consent the secretary was instructed to compile a list of members who ave not paid their dues for the year 1969, nd that each member of the Board of rustees be given a list of these members or their respective districts, so that they nay use it for making personal contact.

Number of members as of December 31, 1968	4,444
1969 members as of May 31, 1969:	
Full dues paying	3,886
Residents and interns	98
Board remitted	54
Senior	340
Honorary	2
Military	43
Total 1969 members as of May 31, 1969	4,423
Total 1968 members as of May 31, 1968	4,363
Number of AMA members as of Dec. 31, 1969	4,289
1969 AMA members as of May 31, 1969	4,273
Full dues paying	3,741
Exempt, but active	532
	4,273
Number who have paid state dues but not AMA dues as of May 31, 1969	148

Headquarters Office

DATE CHANGE FOR HOSPITAL STAFF MEETING—The secretary reported there is a conflict in the Hospital Association schedule and they have requested that the date of the meeting of the elected chiefs of staff, hospital administrators and trustees be postponed from September 10 to September 25. Upon motion of Dr. Steen and taken by consent, the change of date was approved.

AUXILIARY LETTER—The secretary read a letter from the auxiliary, requesting permission to purchase a bookcase at their expense to be installed in the auxiliary room. Their request was approved, upon motion of Dr. Taylor and seconded by Dr. Steen.

The committee then took, for information, a letter from the auxiliary offering the services of a committee of the auxiliary for installing kitchen equipment in the basement.

CHAMPUS LETTERS—Two letters to be sent to physicians by the Champus Department were approved, in principle, upon motion of Dr. Taylor and seconded by Dr. Kintner. Dr. Steen is to rephrase one of the letters.

LETTER FROM CARL MARTZ, M.D.—A letter from Dr. Carl Martz, inviting the executive secretary to serve on the Advisory Committee of the Indiana Program for Emergency Medical Services was read, and by consent, it was agreed the secretary should accept the invitation.

AIR CONDITIONING—The secretary then discussed the problem of air conditioning in the building and the matter of handling heavy freight, and upon motion of Dr. Steen and seconded by Dr. Taylor, this matter is to be referred to the Building Committee.

Treasurer's Report

In the absence of the treasurer and the assistant treasurer, the income and expense statements for April and May, the investments and the cash and security reports were reviewed by the committee and accepted, as printed.

A letter from the Merchants National Bank concerning some investments which were coming due July 10 was referred to the committee and upon motion of Dr. Taylor and seconded by Dr. Steen, the question of reinvesting these funds was referred to the Board Committee on Fiscal Matters.

Organization Matters

REQUEST OF DR. RICHARD L. SCHULTHEIS—A letter from Dr. Richard Schultheis, requesting permission to purchase a mailing list for distribution of a flyer on Maple Grove Manor, a nursing home for children, was approved upon motion of Dr. Steen and seconded by Dr. Kintner.

CORRESPONDENCE BETWEEN DR. CORCORAN AND WFBM—Correspondence between the president and the general manager of WFBM was reviewed for the information of the committee.

REQUEST OF JUDICIAL COUNCIL—A request from the Judicial Council was reviewed for the information of the committee.

U. S. CHAMBER OF COMMERCE LETTER—A letter from the United States Chamber of Commerce concerning SDS was reviewed for the information of the committee.

ANNOUNCEMENT I.U. SCHOOL OF NURSING—An announcement from the Indiana University Medical Center concerning the establishment of a laboratory workshop on Nursing Leadership—Communication and Interpersonal Skills was reviewed for the information of the committee.

AMA LEGISLATIVE REPORT—The June 20 issue of the Legislative Roundup which contained an article that Senator Hartke had introduced S.B. 2424 containing a series of amendments to the Social Security Act, including the inclusion of chiropractic services under the Medicaid and Medicare programs, was reviewed for the information of the committee. The president is to write a letter to Senator Hartke concerning this action.

LETTER FROM INDIANA REGIONAL MEDICAL PROGRAM—A report on the Indiana Regional Medical Program, as contained in the publication, LINK, for the month of May, 1969, was reviewed for the information of the committee.

LETTER FROM DR. OFFUTT—A memo from Dr. A. C. Offutt, on ophthalmia neonatorium prophylaxis was taken as a matter of information inasmuch as Dr. Offutt is to appear before the Board for a discussion of this subject.

LETTER FROM CONGRESSMAN HAMILTON—A letter from Congressman Hamilton, expressing his appreciation for the visitation of the Executive Committee of the association, was read for the information of the committee.

LETTER FROM NATIONAL ASSOCIATION POLICE AND FIRE SURGEONS—A letter from the National Association of Police and Fire Surgeons, requesting the support of the ISMA in publicizing the organization of a National Society of Police and Fire Surgeons was reviewed and, by consent, referred to Dr. Ramsey and *The Journal*.

RECORD OF ABORTIONS—A memo from the Board of Health concerning implementation of House Concurrent Resolution No. 11, by the Board of Health, to establish a system of reporting inter-

rupted pregnancies, was taken as a matter of information, inasmuch as Dr. Offutt was scheduled to report this before the Board.

VOLUNTEER PHYSICIANS FOR VIET NAM—A letter from the AMA concerning awards for three Indiana physicians for their volunteer services in the Viet Nam program was reviewed and by consent it was agreed the awards would be made at the President's Dinner, during the annual convention.

NOMINATIONS FOR AMA COUNCILS AND COMMITTEES—A list of vacancies which occur on the various AMA committees and councils was reviewed for the information of the committee.

Convention Matters

REQUEST OF WALLACE INVESTMENTS, INC.—A request from Wallace Investments, Inc., for exhibit space and for permission to hold one hour meetings during slack periods in some location for the purpose of discussing proper financial and tax planning was reviewed and by consent permission was granted.

REPORT CONVENTION ARRANGEMENTS COMMISSION—A report of the Convention Arrangements Commission was reviewed for the information of the committee.

The convention program was reviewed, and upon motion of Dr. Steen and seconded by Dr. Kintner, the time of the first meeting of the House of Delegates is to be changed from 9:00 a.m. to 10:00 a.m. on Tuesday, October 14.

The question of the employment of the symphony orchestra for entertainment was discussed, and upon motion of Dr. Steen and seconded by Dr. Kintner, the president was authorized to sign the contract for their appearance.

The secretary was requested to determine if the California Wine Institute would be interested in putting on a wine-tasting party during the intermission of the program.

ROBINS PHYSICIAN AWARD—A letter concerning a recommendation for the Physician of the Year Award was read for the information of the committee.

MENTAL HEALTH AWARD—A letter concerning the Mental Health Award was read and, by consent, it was agreed that this would be presented at the time of the President's Dinner at the annual convention.

Legal Matters

TRUTH IN LENDING ACT—Several legal opinions, including one on the Truth in Lending Act, physician's records in compensation cases, medical students substituting for M.D.'s, and the use tax were reviewed for the information of the committee and the secretary was instructed to prepare a *News Letter* so that all members may have the benefit of this information.

STUDENT LOAN COLLECTIONS—A letter from legal counsel concerning the charge for the collection of delinquent student loans, recommending that it be based on the percentage of the recovery rather than a time basis, was approved on mot of Dr. Steen and seconded by Dr. Tay

CHIROPRACTIC ACTIVITIES—T secretary reported on a meeting held the Headquarters Office of several orga zations to discuss the advertising activit of some of the chiropractors in the state Indiana.

LETTER FROM LAKE COUNTY letter from the Lake County Medical ciety concerning a problem which they h with the I.R.S. was reviewed for the formation of the committee.

New Business

LETTER FROM THE DAIRY COU CIL—A letter from the Dairy Council, In requesting they be classified as a scienti rather than a technical exhibitor was proved upon motion of Dr. Steen a seconded by Dr. Kintner.

LETTER FROM I.U.—A letter fr Indiana University concerning an estimat cost of preparing a 16 mm film on a P ceptor Program in the amount of $6,500. was taken for information.

The Journal

SMJAB PROPOSAL—A letter from t State Medical Journal Advertising Bure concerning the sale of our classified a vertising page to a national organizati was reviewed and action was delayed pen ing further information.

There being no further business, t meeting was adjourned to meet again up the call of the chairman during the annu meeting of the AMA in New York.

COMMERCIAL ANNOUNCEMENTS

BUY AND TRY: Wye Plantation Aberdeen-Angus frozen semen from Advanced Register P.R.I. sires officially gaining over four pounds per day or whose 365-day weights are above 1,200 pounds. (Performance tested sires always for sale.) WYE PLANTATION, Queenstown, Maryland 21658. Telephones: 301-827-7166 or 301-827-7160.

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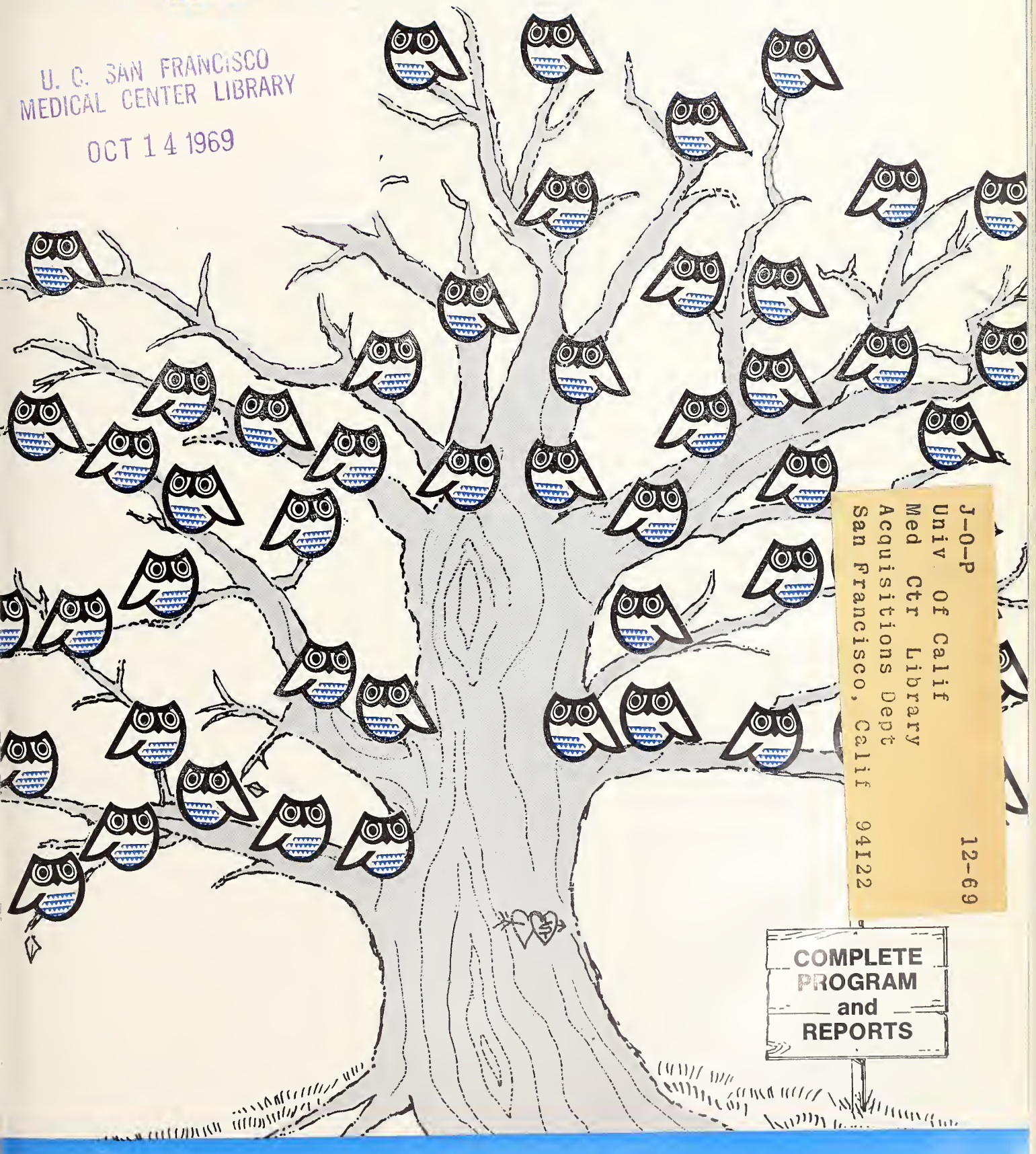
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Indiana Medical Bureau 971
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Lilly, Eli & Company 886
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Indianapolis, Indiana
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September, 1969

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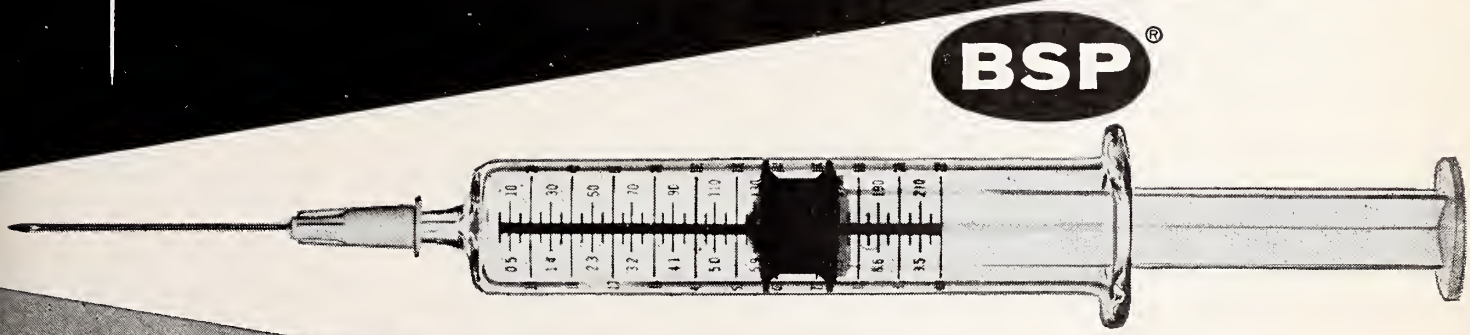
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Contents

SCIENTIFIC

Mycoplasma Pneumoniae in Families—A Therapeutic Study, T. J. Conway, M.D., W. E. Scully, M.D., R. F. West, M.D., K. E. Jensen, Ph.D., L. B. Senterfit, Ph.D., W. W. Drummy, M.D., L. Lenyo, M.D. 1019

X-Ray Conference: Cerebellar Hemangioblastoma, Erich K. Lang, M.D., Shreveport, La. 1026

Electrocardiogram of the Month: Pacemaker Electrocardiography (11), Charles Fisch, M.D., Indianapolis 1028

EDITORIALS

Final Report of the Drug Research Board 1033
Employment of the Handicapped 1033
Three-Legged Stool Revisited 1034
Editorial Notes 1034

CONVENTION SECTION

Section Begins 1041
Table of Contents to Special Convention Section 1042
Art, Hobby Show Application Form 1004
Scientific Exhibit Application Form 1154

SPECIAL FEATURES

New HEW Regulation Limiting Medicaid Fees 1040
Grandpa's Grandpa, Walter C. Bornemeier, M.D., Chicago, Ill. 1123
Medicaid in Indiana, William R. Sterrett, Administrator, Department of Public Welfare, Indianapolis 1126

REGULAR FEATURES

What's New? 1003
President's Page 1005
Fourth Estate 1009
Month in Washington 1013
From The Journal 50 Years Ago 1027
The Woman's Auxiliary Reports to ISMA 1038
Blue Cross and Blue Shield "Best Buy" in Health Coverage (One of a Series) 1130
Gleaned from the British Medical Journal, Jack W. Hickman, M.D., Indianapolis 1136
Medicine At Law 1137
Abstracts, Book Reviews 1144
News Notes 1149
Wanted: Physicians, Locations 1154
Annual Meeting Dates of Professional Medical and Allied Organizations 1155
Future Meetings, Seminars, Courses 1159
News from the I.U. School of Medicine 1160
Board of Health Report 1162
County, District News 1163
Deaths 1164

BUSINESS

Board of Trustees: June 28, 1969 1165
June 29, 1969 1165

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Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as passible.

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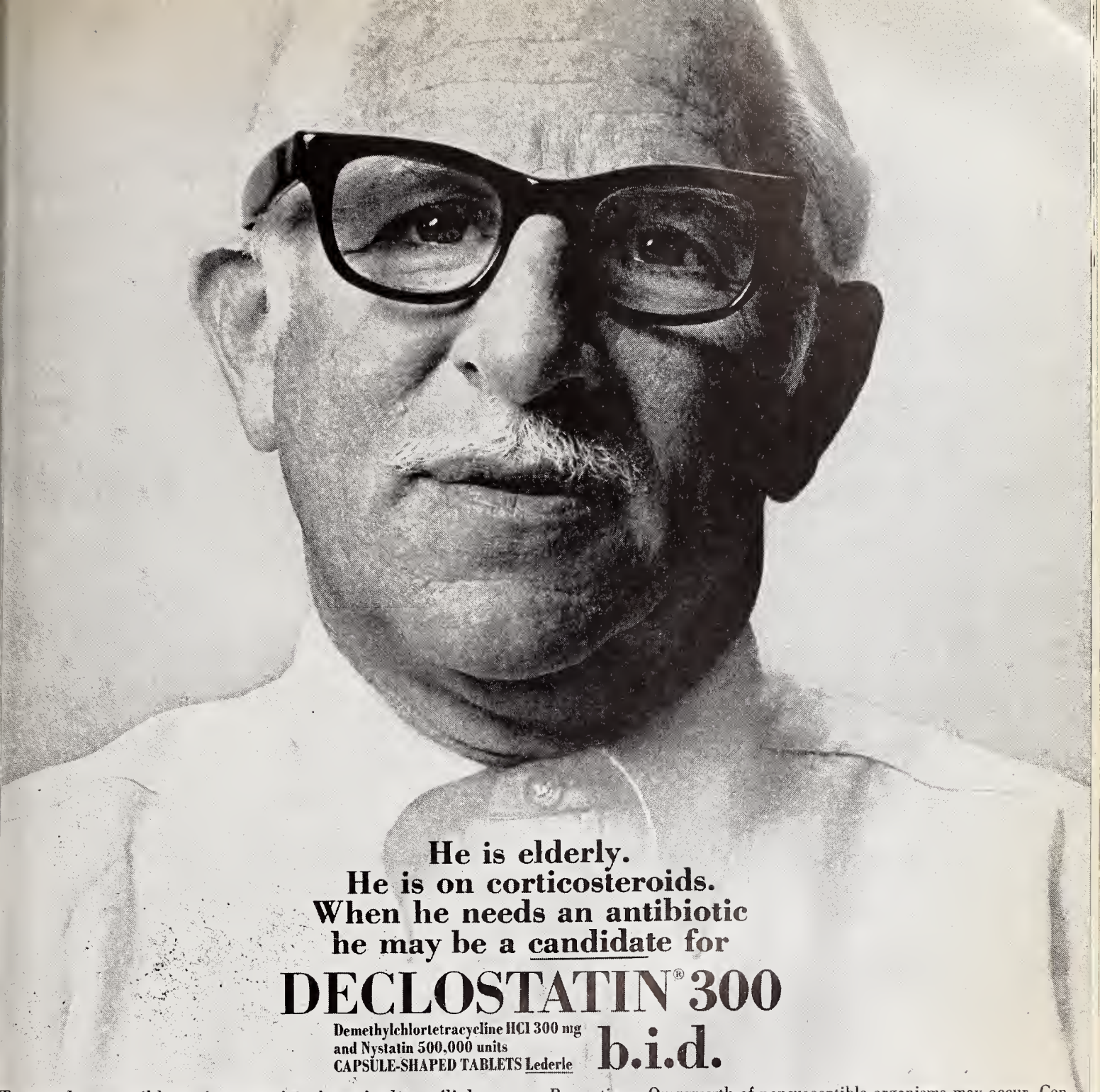
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on page 1024.



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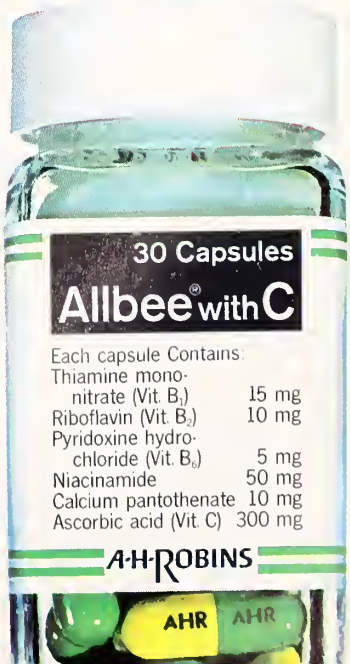
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Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

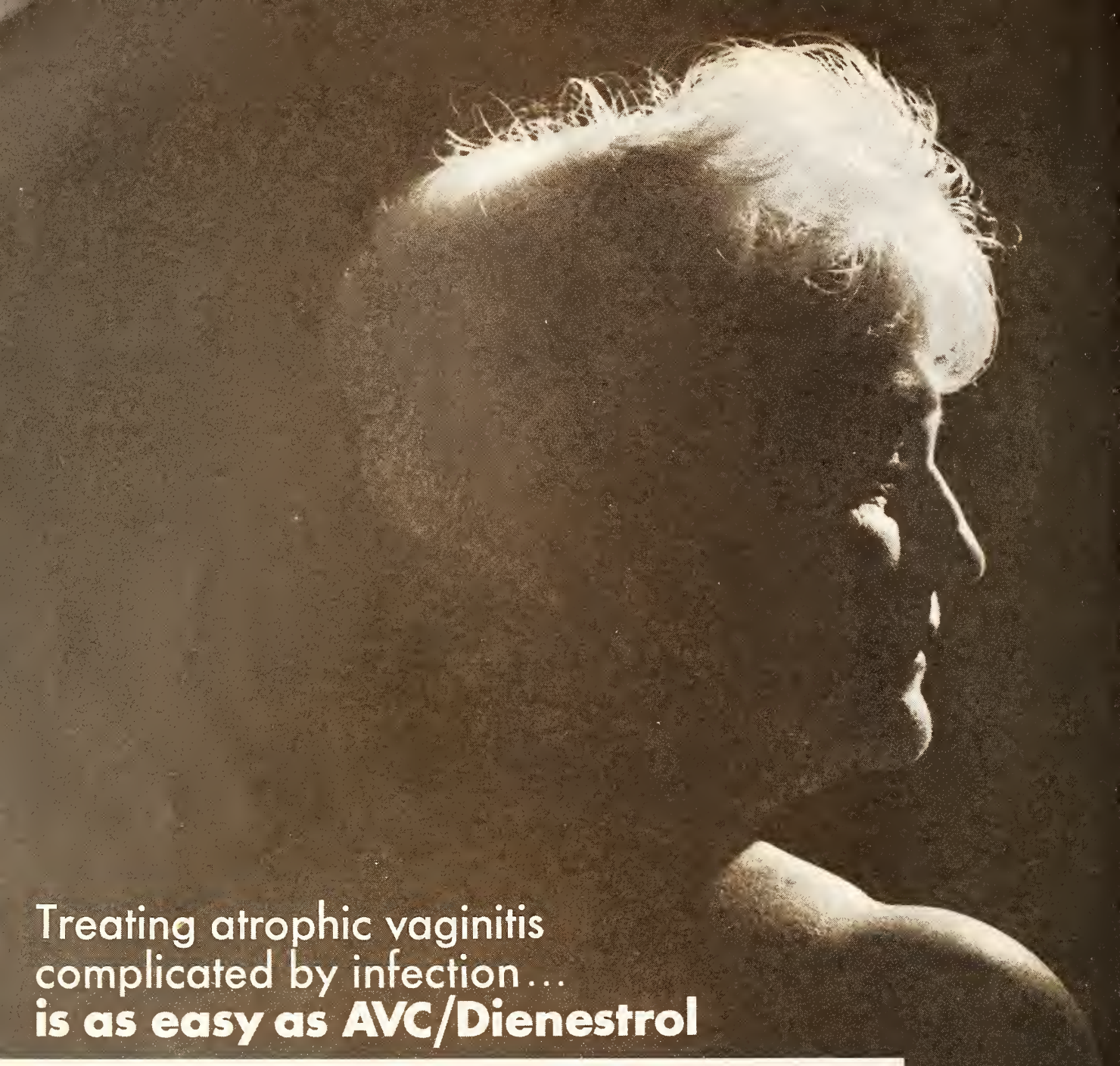
One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastraintestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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(quinine sulfate 260 mg., aminophylline 195 mg.)

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Dienestrol helps restore estrogen-deficient vaginal mucosa.
It is the *particular* ingredient in AVC/Dienestrol that improves cell maturation counts[1,2] — helps stimulate the restoration of normal vaginal epithelium to resist infection.

Two recent studies reconfirm AVC/Dienestrol efficacy.[1,2] AVC/Dienestrol is proven effective against monilial, trichomonal, nonspecific bacterial vaginitis, and mixed infections.[1,2] AVC/Dienestrol combats infection, helps restore tissue resistance to reinfection.

So even in complex cases, the treatment can remain the same. Comprehensive. Effective. Easy as AVC/D.

Contraindications: Known sensitivity to sulfonomides; diognosis or fomiliol history of corcinomo of the genitol troct or breosts; precorcinomotous lesions of the vogino or vulvo; polpoble uterine fibromyomo; mommory fibroodenomo; depressed liver function.

Precautians/Adverse Reactions: The usuol precoutions for topicol ond systemic sulfonomides should be observed becouse of the possibility of obsorption. Burning, increosed locol discomfort, skin rosh, urticorio or other monifestotions of sulfonomide toxicity or sensitivity ore reosons to discontinue treotment. The use of AVC/Dienestrol does not preclude the necessity for coreful diognostic meosures to eliminote the possibility of neoplosio of the vulvo or vogino. Monifestotions of excessive estrogenic stimulotion through dienestrol obsorption moy occur. These include uterine bleeding, breost tenderness, exocerbotion of menstruol irregulority ond provocotion of serious bleeding in women sterilized becouse of endometriosis. Endometriol withdrowal bleeding may occur if use is suddenly discontinued.

Dosage: One opplicotorful or one suppository introvoginolly once or twice doily.

Supplied: 'AVC/Dienestrol Creom'—Four ounce tube *with* opplicotor. 'AVC' ond 'AVC/Dienestrol Suppositories'—Box of 12 *with* opplicotor.

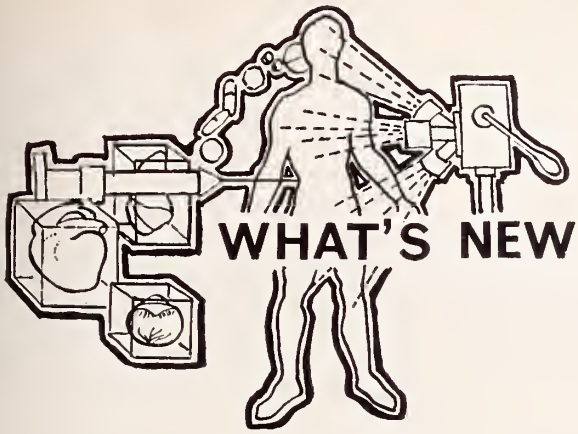
References: (1) Solerno, L. J.; Ortiz, G., ond Turkel, V.: Voginitis: A Diognostic ond Theropeutic Approoch, Scientific Exhibit, presented ot the 115th Annuol A.M.A. Convention, Chicogo, Illinois, June 1966. (2) Nugent, F. B., ond Myers, J. E.: Pennsylvonio Med. 69:44, 1966.

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WHAT'S NEW?

Ortho Diagnostics announces the availability of specific gamma globulin containing anti-Rh antibody. The product is of human origin and is marketed under the trademark name of RhoGAM Rh_0 (D) Immune Globulin (Human). RhoGAM prevents active immunity in the Rh negative woman who has delivered an Rh positive child by suppressing her antibody response to foreign Rh positive cells from the fetus.

* * *

The Upjohn Company has produced a brochure on diabetes as a part of its educational service. "Classification and Management of Diabetes Mellitus," by Arthur Krosnick, M.D., lists atypical signs, describes the stages of the disease and offers suggestions for management at each stage. The booklet is available in quantity for hospitals, medical societies and individual physicians. Write to Diabetes Detection Program, 342 Madison Ave., New York City 10017.

* * *

A new type of implantable cardiac pacemaker that operates only on demand has been developed by the AO Instrument Company of Bedford, Massachusetts. It is designed to prevent undesirable competition between the natural and artificially-induced heart stimuli in patients who still possess sporadic natural heart beat. The fact that the instrument operates on intermittent demand is said to prolong battery life considerably.

* * *

An electric fishing reel, the Reel-Lectric, is now available for use by handicapped children and adults. It is battery-operated and functions like an ordinary spinning reel. It has a button instead of a handle and reels in line when the button is pressed. Only one hand is required for its manipulation. It weighs 26 ounces and has a power-pac which is rechargeable on any 110 volt circuit. Available from the Woodstream Corporation of Lititz, Pennsylvania.

* * *

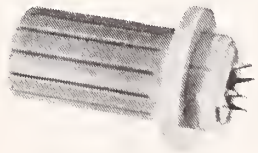
News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratary supplies, instruments, and surgical appliances and baak publishers. Each item is published as news and daes nat necessarily canstitute an indarsement of a product or recammendatian far its use by THE JOURNAL ar by the Indiana State Medical Assaciatian.



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TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



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Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

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Art, Hobby Show Planned For ISMA Indianapolis Meeting

Space will be provided at the 1969 annual meeting of the Indiana State Medical Association, Oct. 13-16 at Indianapolis for a Physicians Art and Hobby Show.

Members of ISMA and ladies auxiliary interested in exhibiting pieces and requiring any information regarding this can contact any one of the following:

Dr. & Mrs. C. P. Schneider
2211 W. Franklin St.
Evansville

Dr. & Mrs. R. H. Burnikel
2709 Washington Ave.
Evansville

Dr. & Mrs. T. E. Caylor
303 S. Main St.
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Dr. & Mrs. F. H. Coble
51 S. Eighth Street
Richmond

Dr. & Mrs. L. G. Montgomery
Ball Memorial Hospital
Muncie

ISMA Headquarters
3935 N. Meridian
Indianapolis

Dr. & Mrs. R. F. Green
614 W. Berry St.
Fort Wayne

Dr. & Mrs. T. T. Suzuki
Covington

Dr. & Mrs. W. L. Harlan
3700 Bellemeade
Evansville

It will be the responsibility of each physician to see that his work gets to the exhibition at the Murat Temple. Final arrangements will be taken care of by Drs. Schneider and Burnikel, co-chairmen.

The ISMA will provide suitable display facilities, but each physician and lady is responsible for transportation costs and any other such expense involved in entering his exhibit.

We solicit your exhibit and that of the ladies auxiliary, to make this the largest and best ever this year.

Application for Space in Art and Hobby Show Exhibit

Mail to:

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville 47712

Name_____

Address_____

City_____

Type and number of pieces to be displayed: Photography_____

Sculpture_____

Crafts_____

Painting_____

Other_____

Estimated amount of space required—lineal or square feet_____

Other information_____

President's Page

Important New Commission

A Commission on Medical Education has been set up by Governor Whitcomb. Thirty members have been appointed, representing the public, the universities, and the health professions. Ten doctors of medicine, one osteopath, and one dentist are included.

Its mandate is to inventory the resources for programs of health care education in the state and to make recommendations for improvements. This is a big task. It will not be quickly or easily completed.



The great public interest in medical education is due to increasing health care manpower shortages. It is assumed by many that if more physicians are educated in the state, more will be delivering health care in the state. This may not be proportionately so. However, some percentage of any increased number of graduates will remain involved in medical activity in the area.

The training of more physicians is only a part of the answer. Work simplifying techniques and refinement of present procedures in the delivery of health services can be of equal importance. The utilization of ancillary health professionals can be expanded.

Quality health care may be more efficiently distributed and be made more widely available by improved transportation and by new communications methods.

The organization of the medical school (or schools), the composition of the faculty, the curriculum and the facilities all need critical re-evaluation in light of the profound changes that will surely come within the next ten—or even five—years. The end-product of medical education must be fashioned to meet the needs as nearly as they can be predicted.

A single mold will not suffice for tomorrow's doctor. The training will be more flexible, emphasizing electives, with a core of basic subject material.

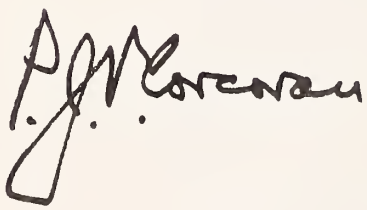
Admissions procedures to medical school deserve very careful scrutiny. Academic qualifications and high scholastic achievements are not always the crucial criteria in selecting future physicians.

A broad-gauged study should be made of the motivations that draw a student toward the health professions, and, once enrolled, that attract him to a particular phase of it. Also, the factors which impel him to stay or to leave the state can be sought and identified. The qualities that make a teacher or a research scientist should be distinguished from those which lead to becoming a good practitioner, who will actually be delivering health care.

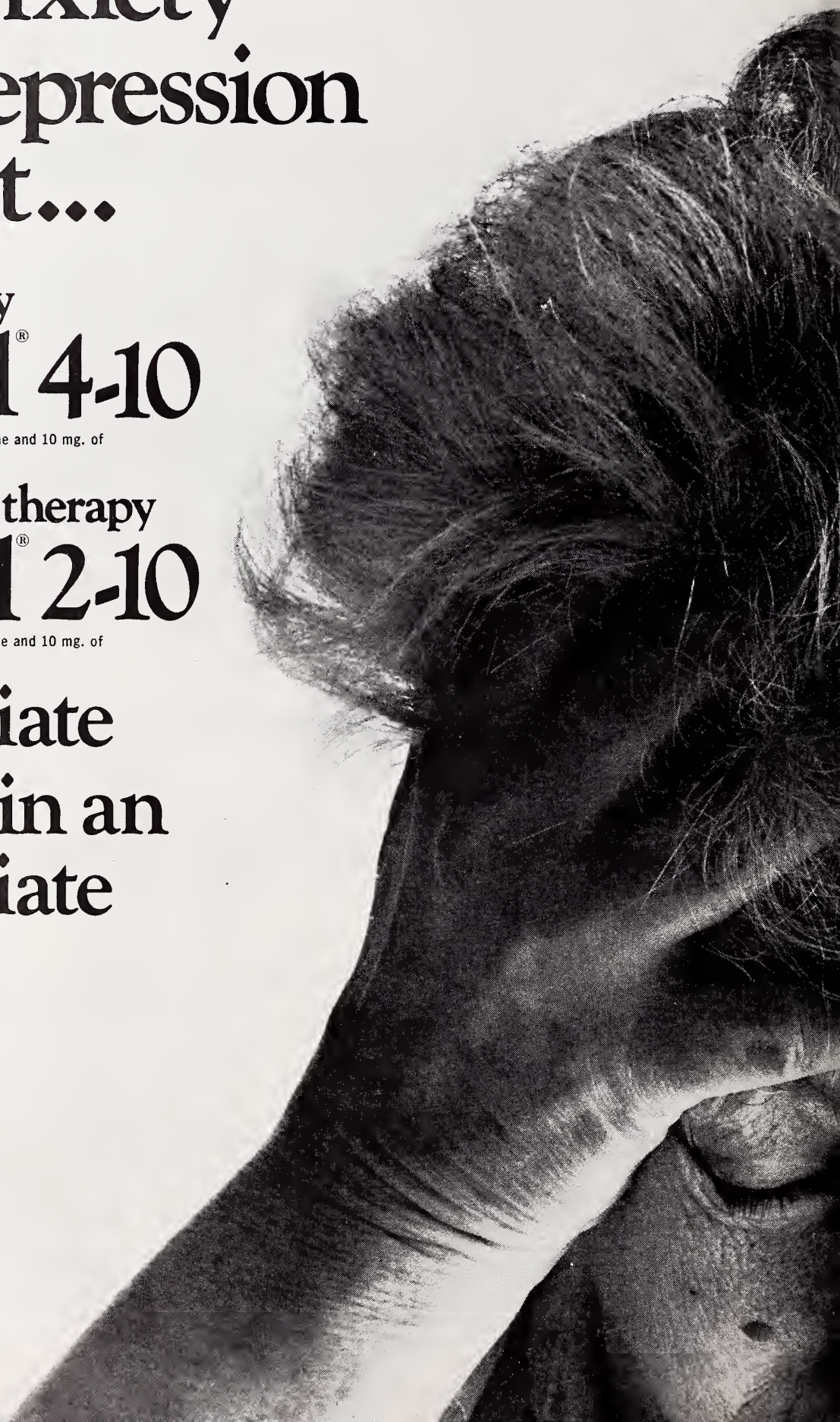
Such data could be useful in recruiting the best candidates and in admitting the proportions of the types to be trained, according to probable needs.

We can surely find the resources to make such a study. It has pertinence to the total program.

The Governor's Commission has begun its work with dedication and with sincere interest in developing positive and practical proposals to present promptly. I welcome any ideas or suggestions which you may wish to offer for consideration.



when it's late in life and anxiety and depression coexist...



initial therapy

Triavil® 4-10

Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride

maintenance therapy

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Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

appropriate therapy in an appropriate dosage



During the years of declining strength and increasing infirmity, many patients are more sensitive to both the desired response and the unwanted effects of some drugs. That's when low-dosage therapy is needed. And that's when TRIAVIL 4-10, as initial therapy, and TRIAVIL 2-10, for maintenance, can prove particularly useful.

Starting with TRIAVIL 4-10 should help minimize possible dose-related side effects in the geriatric patient with coexisting anxiety and depression. And, subsequently, TRIAVIL 2-10 can increase flexibility in adjusting maintenance dosage.

Activities made hazardous by diminished alertness should be avoided. You will want to inform your patients that the effects of alcohol may be potentiated. Because of the potentiation of other drug effects possible with MAO inhibitors, such agents should not be given concomitantly with TRIAVIL. However, therapy with TRIAVIL can be initiated cautiously two weeks or more after withdrawal of the MAOI drugs. And, until significant remission is observed, close supervision of any seriously depressed patient is, of course, essential to guard against possible suicide. The drug is contraindicated in glaucoma, in patients expected to experience problems of urinary retention, in drug-induced CNS depression, and in bone marrow depression.

TRIAVIL 4-10 & 2-10—tranquilizer-antidepressant therapy especially appropriate for the elderly patient so often intolerant to medication in high dosages.

TRIAVIL® for moderate to severe anxiety with coexisting depression

containing perphenazine and amitriptyline HCl
TRANQUILIZER-ANTIDEPRESSANT

For additional prescribing information, please see following page.



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TRIAVIL 4-10: Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.
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TRIAVIL 4-25: Each tablet contains 4 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.
TRIAVIL 2-10: For use in adjusting maintenance dosage. Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

for moderate to severe anxiety with coexisting depression

INDICATIONS: Patients with moderate to severe anxiety and/or agitation and depressed mood; patients with depression in whom anxiety and/or agitation are severe; patients with depression and anxiety in association with chronic physical disease; schizophrenics with associated depressive symptoms.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; urinary retention; pregnancy; glaucoma. Do not give in combination with MAOI drugs because of possible potentiation that may even cause death. Allow at least 2 weeks between therapies. In such patients therapy with TRIAVIL should be initiated cautiously, with gradual increase in the dosage required to obtain a satisfactory reponse.

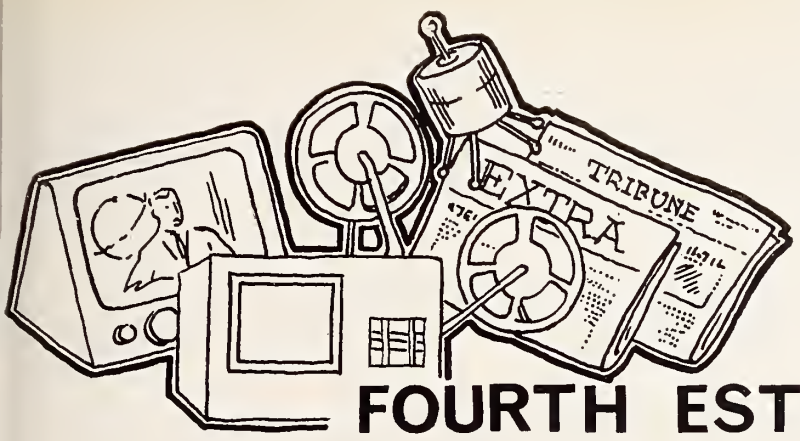
WARNINGS: Patients should be warned against driving a car or operating machinery or apparatus requiring alert attention, and that response to alcohol may be potentiated.

PRECAUTIONS: Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having various modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Not recommended for use in children. Mania or hypomania may be precipitated in manic-depressives (perphenazine in TRIAVIL seems to reduce likelihood of this effect). If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Caution patients about errors of judgment due to change in mood.

SIDE EFFECTS: Similar to those reported with either constituent alone. **Perphenazine:** Should not be used indiscriminately. Use caution in patients with history of convulsive disorders or severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; severe, acute hypotension (of particular concern in patients with mitral insufficiency or pheochromocytoma); skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); grand mal convulsions; cerebral edema; altered cerebrospinal fluid proteins; polyphagia; paradoxical excitement; photophobia; skin pigmentation; failure of ejaculation; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia; significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol), atropine, heat, and phosphorous insecticides. **Amitriptyline:** Careful observation of all patients recommended. Side effects include drowsiness (may occur within the first few days of therapy); dizziness; nausea; excitement; hypotension; fainting; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of latent schizophrenia (however, the perphenazine content may prevent this reaction in some cases); epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration, or transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of mouth, blurring of vision, urinary retention, constipation, paralytic ileus; agranulocytosis; jaundice. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

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FOURTH ESTATE

This section of THE JOURNAL is devoted to the presentation of opinions which appeor on the editoriol poges of the public press, ond which ore of interest to the medical profession. Its function is to review comments which moy be fovoroble or unfovoroble to medicine. Members ore invited to submit editoriol clippings for this column.

A Bid for More Family Doctors

As a matter of probable interest to many Hoosiers, we note the passage and approval by Governor Rockefeller of a New York State legislative act frankly designed to draw more medical students into careers as general practitioners.

The New York act is not a particularly strong one, providing only that each state university medical center organize a department of general practice and requiring the presentation of certain courses relating to such general practice. How the students will respond, of course, is an unpredictable factor.

However, the act does bring to mind the proposals for the establishment of a medical school oriented toward the *education of general practitioners* at Ball State University. The proposals reflected apprehensions of many laymen, and medical men too, that over-specialization is creating a vacuum in the medical profession. The profession, as such, has not been overly anxious to come to grips with the question—probably because it already has become so highly specialized.

Strong arguments can be made for and against the present trend toward specialization. However, the question should not be abandoned to solve itself through purely pecuniary aspects of the profession. Perhaps there is something to the proposition that general practice, itself, should be regarded as an area of specialization.—*Fort Wayne News-Sentinel*, May 8, 1969.

Could Be a Gary Health Break

That's sort of a double side door by which Gary got the latest of its sons into the national limelight.

In the first place, it is well known that Dr. Roger O. Egeberg was not the first choice of Health, Education and Welfare Secretary Robert Finch for his assistant secretary of health services. But the American Medical Association (AMA), with powerful Senate support, blocked that first choice, Dr. John H. Knowles.

In the second place, Dr. Egeberg — a surprise compromise who seems to please both the AMA and such Senate liberals as Republican Jacob Javits — left Gary after the 10th grade at Emerson and has been back only on visits since.

Nevertheless, Gary is proud to claim him as we were proud to claim Frank Borman who left here even earlier and then went on to deserving fame as the commander of the first manned trip around the moon.

But there could be more than mere pride where Egeberg is involved.

Gary has a mounting interest in health problems. It was demonstrated by the great success of the $5 million plus Gary Joint Hospital drive. It is indicated in continuing intensive efforts to have a medical school located in Lake County. It underlies an increasing interest in speeding up lagging air pollution efforts and pushing on with new attacks on water pollution.

Having a former Gary man in that top health post just could prove a Gary asset.—*Gary Post-Tribune*, July 3, 1969.

Medicaid's Pitfalls

In just six months Indiana will join the list of states participating in the federal Medicaid program. Under it, the cost of medical treatment for welfare recipients will be borne by the state, assisted by a heavy federal subsidy, rather than by the local county welfare office.

This will mean a substantial reduction in the county property tax rate for welfare, a welcome relief. But it does not save money in the long run, merely shifting the expense to different forms of taxation.

As shown by the experience of other Medicaid states, the danger in the state-federal system is that loose administrative control will make the same amount of medical assistance cost more than it does today.

Operation of Medicaid in some states has been an outright scandal.

Unfortunately there are "gyp" artists among doctors, hospitals, pharmacists, and other vendors of medical services who have found Medicaid ripe for the plucking. In California, for example, the state

Continued

attorney general's office estimates that Medi-Cal, as that state calls its Medicaid program, is being bilked of $6 to $8 million a year in "illegal and unethical activities."

Reports of immense payments to individual doctors and druggists, often for services which seem skimpy and hasty, have come from many states. Unnecessary refills of prescriptions and needless return visits to doctors have been cited by investigators, as well as high charges for simple services.

Indiana has the advantage of studying errors made in other states. Among the worst have been failure to provide enough fraud investigators, and insufficient scrutiny of bills submitted by medical vendors before they are paid.

Close examination of these bills at the county welfare level has been replaced by less rigid state inspection in some states, increasing the opportunities for fraud.

Also, Indiana enters Medicaid on a limited basis, applying it only to welfare recipients and not the broader group of non-welfare citizens called the "medically indigent." This should make control easier.

Introduction of Medicaid in Indiana next Jan. 1 provides Gov. Whitcomb's regime an opportunity to show its ability in economic administration. If it fails to have rigid rules and equally tight enforcement, serious waste of state money may result.—*South Bend Tribune*, July 1, 1969.

Two New Hopes, One Clouded

Gubernatorial action has in part reawakened hopes for two vital Northwest Indiana projects, though it leaves one of them under something of a cloud.

Gov. Edgar Whitcomb's appointment of committees to consider state needs in medical education and to advise on a flood control program for the Little Calumet River are the key actions.

But in appointing the medical committee, the governor stated that the new commission "may consider that the school of medicine at Indianapolis should continue as the primary center in the health care professions for the immediate future."

That would seem to put him in step with some of the leadership of the I.U. Medical School at Indianapolis which has argued that supplementary medical education programs might be set up at various sites in the state with principal education of doctors being retained in the capital.

Those concerned with the marked shortage of doctors in this second most populous area of the state still believe that more positive action is needed. What they advocate is the setting up of a second medical campus here. We think they are right.

However, there could be two bases for hope. One is that the governor's study commission will reach that conclusion despite Whitcomb's own remarks. The other is the meaning of the phrase "immediate future." It is hardly contemplated by many that a medical school could be set up immediately. What they argue is that such a program should be launched now because of the time and money required once the start is made.

The Little Calumet committee is of more immediate importance. The Army Corps of Engineers is scheduled to wind up its Little Calumet feasibility report soon. Area and state governmental agencies have drawn up a proposal based on a combination of flood control and recreational advantages which could result from widening and straightening the stream and controlling development in its flood plain.

There was disappointment when the legislature emasculated and the governor finally vetoed a bill which would have given the project more official state support. The hope now is that Whitcomb's action appointing the committee will recoup most of the ground tentatively lost at that time.

Certainly the committee should provide the vehicle for underscoring this area's needs insofar as federal help on a Little Calumet project is concerned.—*Gary Post-Tribune*, June 18, 1969.

Dr. Leslie W. Freeman

Dr. Leslie W. Freeman had won international distinction and many honors in his busy career as a neurosurgeon and as director of neurological research at the Indiana University School of Medicine.

The honors were well deserved because he contributed tremendously to the advancement of medical procedures for treating sufferers from paralysis. As a neurosurgeon during World War II, many soldiers with spinal injuries were brought to him for treatment and he operated immediately, believing this was an important step in preventing impending paraplegia.

His interest in paraplegic victims continued, and after the war he built and later directed paraplegic centers for the Army. He then came to the I.U. Medical School in 1948, where the work by him and his staff in neurological research has received international recognition.

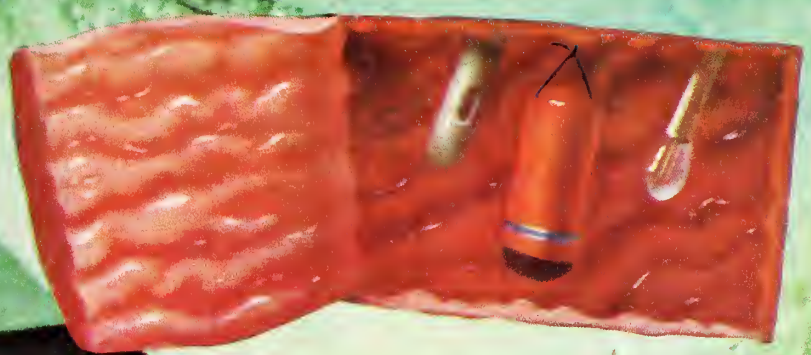
The National Paraplegic Foundation, which he founded, had given him its distinguished service award. He gave the honorary lecture at the Latin-American Congress of Neurosurgery in Buenos Aires in 1963. He had written 70 articles and chapters of books on the spinal cord.

Probably the honor that brought him the greatest satisfaction was a plaque from the Paralyzed Veterans of America for 10 years of outstanding work in paraplegia.

Dr. Freeman died this week at the comparatively young age of 53. There can be no better tribute than the gratitude of countless paraplegic victims to whom he had given new hope. —*Indianapolis News*, July 11, 1969.◀

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nsistently scored high in degree and uration of intragastric buffering

ploying aspiration of gastric juice, indwelling electrode, d/or Heidelberg telemetering capsule techniques,* studies olving 79 subjects with or without proven peptic ulcer dis-se compared intragastric buffering capacity of Gelusil-M d 1 or the other or both of 2 leading ethical antacids, using mparable doses.*

l three antacids raised the pH above 3.5, an accepted cri-ion for antacids. The amount of time above this pH helps characterize the buffering activity of an antacid. While it not implied that a direct therapeutic correlation exists, ese techniques do, however, objectively demonstrate the ffering characteristics of this new antacid in terms of onset action, peak pH, duration of buffering action.

lean peak pH*

elusil-M, mean peak pH 6.6 (range: 5.6-7.8).
ntacid A, mean peak pH 5.5 (range: 4.2-7.5).
ntacid B, mean peak pH 5.5 (range: 4.4-6.3).

Mean duration of buffering action above pH 3.5*
Gelusil-M, 29.8 mean minutes (range: 18.0-51.8 minutes).
Antacid A, 24.6 mean minutes (range: 6.3-48.0 minutes).
Antacid B, 23.3 mean minutes (range: 5.9-50.0 minutes).

Mean duration of buffering action above pH 5.0*
Gelusil-M, 23.2 mean minutes (range: 14.3-43.9 minutes).
Antacid A, 10.1 mean minutes (range: 6.7-12.2 minutes).
Antacid B, 16.3 mean minutes (range: 8.0-24.2 minutes).

Onset of action*
In speed of intragastric buffering action, Gelusil-M, Antacid A, and Antacid B were consistently rapid and not measurably different.

*References: Antacid studies, data on file, Warner-Chilcott Labaratories Division.

introducing new

GELUSIL®-M

each 5 ml. teaspoonful contains:
500 mg. magnesium trisilicate, 250 mg. aluminum hydroxide (Warner-Chilcott), 200 mg. magnesium hydroxide
U.S. Patent No. 3,326,755

a consistent buffering anticostive† antacid

† Avaids canstipation.

See next page for prescribing information ►

GELUSIL–one name to remember...and a dosage form for every patien



Gelusil®-M Liquid

especially for the constipation-prone patient

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

Supplied: Gelusil-M (spearmint-flavored)—light green bottles of 12 fl. oz.; and a **special hospital pack.** Keep tightly closed—shake vigorously.

Gelusil® Tablets

the universal take-along antacid

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

Regular Gelusil® Liqui

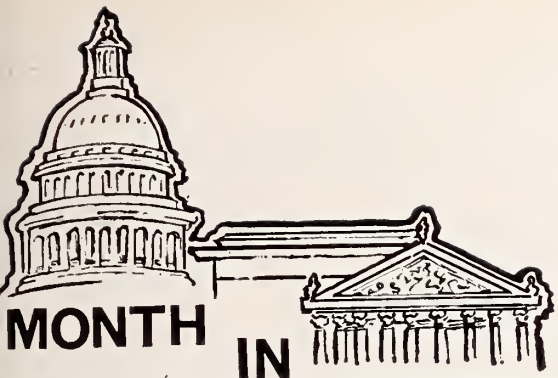
when constipation is not a problem

Pleasant mint flavor...ideal for hosp tal or home. Available in 12 fl. oz. an 6 fl. oz. bottles and a special hospit pack. An antacid which contains adso bent and demulcent agents in each ml. teaspoonful: 0.25 Gm. aluminu hydroxide (Warner-Chilcott), 0.5 Gm magnesium trisilicate (USP).

Dosage: 2 teaspoonfuls (4 ml. each)- or more—between meals and at bed time, or whenever symptoms occur.

Also Available: Gelusil® Flavor-Pack Gelusil-Lac®.

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MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

WASHINGTON, D.C.—The American Medical Association questioned whether the Department of Health, Education and Welfare has the authority to issue its recent regulation limiting physicians' fees under medicaid.

"WE QUESTION whether the authority granted by the Congress embraces the promulgation of this regulation," Dr. Ernest B. Howard, executive vice president of the AMA, said in a letter to HEW.

"THIS REGULATION appears to reverse the roles of state and federal government established in the law itself."

THE REGULATION limits most physicians' fees to the 75th percentile of the customary charge—the maximum customary fee of 75% of the physicians in the area.

AFTER OFFERING HEW the cooperation of the AMA in its efforts to contain rising medicaid costs, Dr. Howard pointed out that the "comprehensive" care goal of the program could not be achieved "without substantial funding, both state and federal."

"MOREOVER, it has always been recognized that the intent of Title XIX (medicaid), when adopted, was to dissolve any barriers which existed between medical care available to the medically indigent and other citizens," the AMA statement said.

"IT ALSO recognized that payment to physicians participating in the government program should be on the basis of reasonable charges, i.e., usual charges of the physician within the customary range of charges for similar services in the community, so as to assure a broad range of participation by physicians in the program and eliminate one of the obstacles to the care of patients on the same level as that provided other persons in the community. This was essentially the approach taken in the January 25, 1969, regulations concerning 'reasonable charges,' in which 'customary charges which are reasonable' was established as the upper limit for payment for non-institutional services. We believe that the January 25th pronouncement more accurately comports with the Congressional intent expressed in Section 1903(a) (30) of the Medicaid law, than does the regulation. . . .

Continued

"IN DEPARTING from this earlier standard, by establishing arbitrary limits on payments to individual practitioners, it should be recognized that the July 1 regulations may again raise a barrier to providing private care to the medically indigent.

"THERE CAN BE no question that any fee abuses in the program, whether by individual practitioners or other providers, must be ferreted out and eliminated. On the other hand, the true effect of the proposed regulations must be kept in proper perspective, since physicians' fees represent only approximately 11% of the costs of the Medicaid program. Consequently, if the basic concern is with the total costs of the program, the remedy in our opinion, is not through regulations which restrict physicians' charges."

ON THE Congressional front, the medicaid law was amended to give the states some relief in fiscal difficulties arising from the program.

STATES NOW have until July 1, 1977, to submit comprehensive plans of medical care for all needy persons under medicaid. Under the original medicaid law, participating states had to come up with such a plan by July 1, 1975. But rising health care costs resulted in medicaid fiscal difficulties for so many states that Congress delayed the deadline for two years and relaxed other requirements to ease the financial bind.

ONE OF THE new amendments permits states to reduce their services under medicaid. In the past, they couldn't. But a state still cannot reduce overall medicaid spending.

REP. WILBUR D. MILLS (D., Ark.), chairman of the House Ways and Means Committee, said the changes in the law should give states some financial relief and also give Congress time to consider what long-range revisions are desirable in medicaid.

NIXON PREDICTS "MASSIVE" CRISIS IN HEALTH CARE

PRESIDENT NIXON said the nation will be confronted with a "massive" crisis in health care unless government and the private sector cooperates to hold down costs and to improve the system of delivery of medical services.

HE MADE the statement in commenting on the Health, Education and Welfare Department's "Report on the Health of the Nation's Health Care System." It carried the names of both HEW Secretary Robert H. Finch and HEW Assistant Secretary for Health and Scientific Affairs Roger O. Egeberg, M.D.

"THIS NATION is faced with a breakdown in the delivery of health care unless immediate concerted action is taken by government and the private sector," the report said. "Expansion of private and public financing for health services has created a demand for services far in excess of the capacity of our health system to respond. The result is a crippling inflation in medical costs causing vast increases in government health expenditures for little return, raising

private health insurance premiums and reducing the purchasing power of the health dollar of our citizens."

THE REPORT said the medicaid program—"badly conceived and badly organized"—was a major factor in rapidly rising health care costs by attempting "to provide medical services for the poor by pushing them into the nation's already overburdened health care system without developing the capacity in the system to serve them and without building the capability in the states to manage the program."

THE REPORT ALSO said overtaxed health resources are being used wastefully and not being expanded rapidly enough. And not enough attention is being given to preventive health care, the report said.

TWO ADVISORY groups were set up: a HEW Secretary's Task Force on Medicaid and Related Programs under co-chairmen HEW Undersecretary John G. Veneman and Walter J. McNerney, president of Blue Cross, and a special industry group with David J. Mahoney, president of Norton Simon, Inc., as chairman.

DWIGHT L. WILBUR, M.D., then president of the American Medical Association, congratulated the Nixon Administration for taking "such a thoughtful look at the accumulated problem that has been built up in the past as a result of hurriedly enacted programs, the buildup of unattainable expectations and creation of unsound administrative operations."

"CORRECTING the consequences of massive disruptions and past political errors will call for the cooperation and dedication in the government and private sectors," Dr. Wilbur said. "This includes physicians, other professionals, many in related fields, hospitals, government, insurance payors and many others."

DR. WILBUR also welcomed a call by Finch and Dr. Egeberg for discipline through the profession itself of "the very few members of the medical profession who have reportedly abused the (medicare and medicaid) programs."

AMA WITNESSES TESTIFY

RECENT TESTIMONY by AMA witnesses before Congressional committees included:

—DR. O. L. SIMENSTAD, member of the AMA Board of Trustees, before the Senate Monopoly (Nelson) Subcommittee:

"The advertising policies of the AMA have recognized consistently the uniqueness of drug advertising in that it should not be directed to the public, but to physicians, and because of the public interests involved, it should be responsibly presented. As the drug products in this country have become more sophisticated, the association's advertising policies have undergone evolution. Initially, an 'ethical' manufacturer was required to disclose the formula of his advertised products. 'Secret nostrums' could not be advertised in responsible medical journals such as JAMA. Today, honest presentation of claims is the primary criterion. . . .

"The policy of the AMA has been to update the advertising standards as the drug field changes. Two of the basic

Continued

tenets have remained unchanged, however. One is that 'the appearance of advertising in AMA publications is not an AMA guarantee or endorsement of the product or the claims made for the product by the manufacturer' and the other is that advertising space will not be sold unless 'the inclusion of advertising material does not interfere with the purpose of the publication.' "

—DR. PIERRE SALMON, member of the AMA Committee on Aging, before the Senate Long-Term Care Subcommittee:
"We believe that the medical profession should take the lead in organizing 'community coordinating committees' to assume overall responsibility in coordinating available health facility services in the community. We have suggested that local medical societies invite representatives of the other health agencies and professions in the area to discuss and consider jointly the community's particular problems with regard to long-term care—both convalescent and custodial care. Some local medical societies have taken this initiative."

—DR. FREDERICK C. SWARTZ, chairman of the AMA Committee on Aging, before the Senate Subcommittee on Health of the Elderly:
"Age is no bar to good medical or surgical treatment including open heart surgery, so long as the patient presents himself as a reasonably physiologically functioning unit to the physician."
"The medical and paramedical services—the physician and the para-physician personnel—must begin to realize that something can be done for diseases found among the oldsters. The days of condescension medicine to 'grandpap' and 'grandma' is at an end."

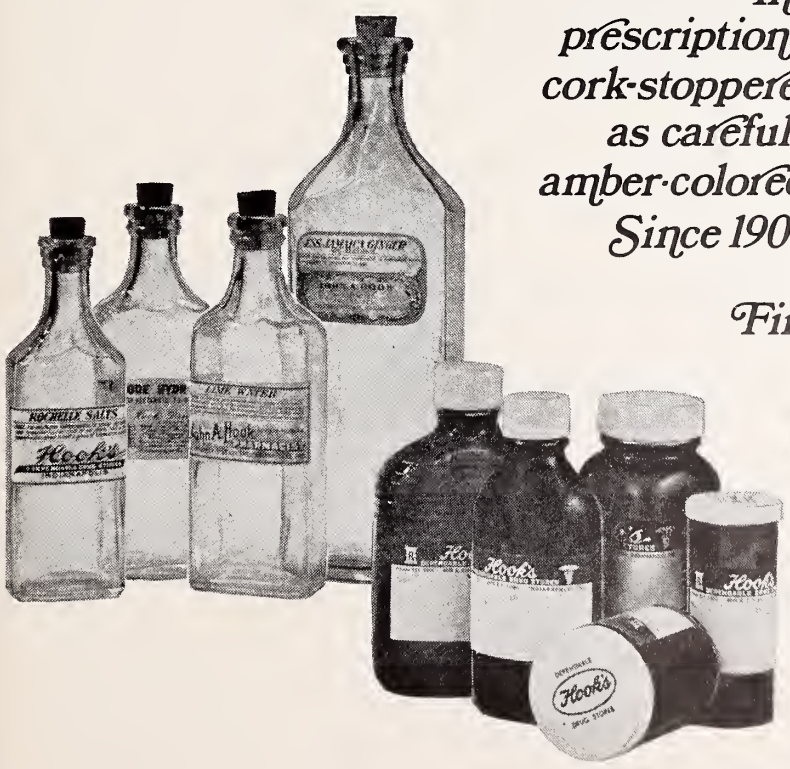
—PHILIP L. WHITE, secretary of the AMA Council on Foods and Nutrition, before the Senate Committee on Nutrition and Human Needs:
". . . the United States needs to develop a national nutrition policy. . . . The development of goals in food production and distribution, the establishment of adequate levels of nutrient intake for individuals and groups of people, plans for the nourishment of our future expanded populations are but a few of the issues which require national attention."

—DR. HENRY BRILL, chairman of the AMA Committee on Alcoholism and Drug Dependence, before the House Education Subcommittee:
"In the course of the AMA's work in this field, we have been profoundly impressed by the fundamental importance of public education about narcotic, depressant and stimulant drugs. In the first instance, of course, public information has a decisive impact on public attitudes

and opinions, and in the long run this determines public policy. If drug taking for pleasure should ever become socially acceptable in this country and accepted as a harmless pastime, one could confidently predict that control of drug dependence would become impossible."

—DR. MARVIN A. BLOCK, a member of the AMA Committee on Alcohol and Drug Dependence, before the Senate Subcommittee on Alcoholism and Narcotics:

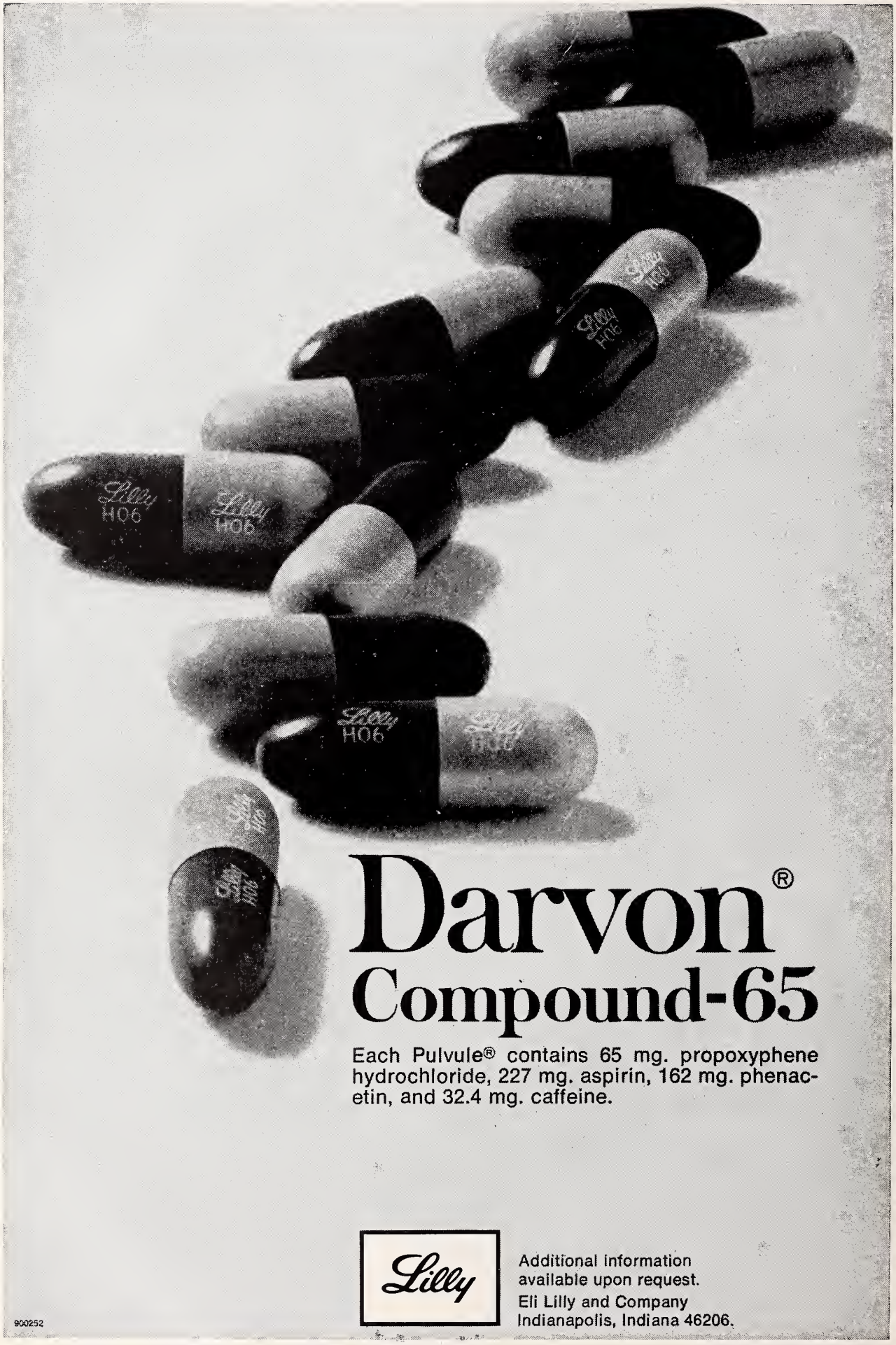
". . . the crying need, aside from that of research and education, is for community facilities to treat and care for the alcoholic patient, who is entitled to the same rights and opportunities for treatment accorded other sick people."



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The Journal of the INDIANA STATE MEDICAL ASSOCIATION
Supervised by THE COUNCIL
Volume 62 — September 1969—Number 9

An epidemic of Mycoplasma pneumoniae infection was encountered and studied during the first four months of 1965 in Terre Haute, Indiana. Family members of all cases were tested for concomitant infection by culture and by serologic methods.

Mycoplasma Pneumoniae in Families— A Therapeutic Study*

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R. F. WEST, M.D.[1]
K. E. JENSEN, Ph.D.[2]
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Terre Haute

SINCE the time when all cases of non-lobar, non-pneumococcal pneumonia were labeled as "atypical pneumonia," there have been many refinements in classification. In 1944, Eaton, Meiklejohn, and Van Herick were able to isolate a filterable agent from those patients whose elevated cold agglutinin and streptococcus MG titers fit the classification of primary atypical pneumonia (P.A.P.).[1] Then, in 1949, Meiklejohn and Shragg reported that patients suffering P.A.P. showed clinical improvement when treated with chlortetracycline, demonstrating that a broad spectrum antibiotic could be effective in counteracting a disease then considered of viral etiology.[2] There followed conflicting reports as others attempted to duplicate these results.[3] The "Eaton agent" remained an unknown quantity, while many specific viruses were being consistently identified by newer methods of virus recovery.

Using the fluorescent antibody technic on paired sera from patients with P.A.P., Liu proved the association of the Eaton agent and P.A.P. in 1959.[4] Chanock and associates were able to produce P.A.P. in volunteers inoculated with the agent; and then, most significantly, in 1963, they demonstrated that the etiologic agent was in fact a pleuropneumonia-like organism (PPLO). They suggested it be called *Mycoplasma pneumoniae*.[5-8] The etiologic story was thus intact, and the efficacy of tetracycline therapy the more understandable, since mycoplasmas are not viruses, but the smallest known independent life forms. They lack the rigid cell wall of bacteria and fungi but will grow and multiply in lifeless media.

As early as 1962, Rifkind and others called attention to the middle ear involvement of volunteers infected with the Eaton agent,[9] and later studies have suggested that children more frequently suffer such myringitis.[10-13] Clyde and Denny have provided a review of mycoplasmal disease as it affects children.[14] Grayston et al. in Seattle and Balassanian and Robbins in Cleveland have carefully studied the intrafamily transmission of mycoplasma infections during its slow spread through civilian communities.[10,11,15]

During one such period in 1963 in Terre Haute, Indiana, an empirical scheme of family therapy was at-

* Oxytetracycline (Terramycin®) for this study was provided by Pfizer Company.

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[3] Biologics Research Dept., Chas. Pfizer & Co., Inc., Terre Haute 46808. Present address: Department of Pathology, St. Louis University, St. Louis, Mo. 63103.

tempted and found to be seemingly effective. Therefore, when the next epidemic of *M. pneumoniae* infection was encountered, this study was devised to investigate household spread and to evaluate family therapy.

Materials and Methods

In January, 1965, it was evident that *M. pneumoniae* infections were prevalent again. Pharyngeal cultures from 17 suspected cases (all children) were obtained, and the organism was grown and identified in 15 of them. This demonstrated the feasibility of clinical selection of cases and set in motion the following study.

Private patients of the Departments of Pediatrics and Internal Medicine at the Associated Physicians and Surgeons Clinic were invited to participate in the program if their symptoms and signs fit the criteria considered clinically diagnostic. Malaise, cough, mild fever, coryza and ear pain were the usual complaints. Mucoid rhinitis, otitis media, inspiratory rales and expiratory wheezes were the common findings, and the degree of toxicity was generally mild. Only one patient, a three-month-old infant, was hospitalized during the study. Perhaps knowledge of the disease and its natural course helped patients, parents and physicians to have confidence in home care.

As expected, description of the program to the patient often prompted the reply that others at home were already ill. This strengthened the suspicion that these organisms were widely spread among family members. Patients selected were given written instructions outlining their role in the study. Each patient became an index case with symptoms and signs recorded. A blood count and throat culture for bacteria were done at the outset. Weekly chest x-rays were continued until the findings were normal. Throat cultures for *M. pneumoniae* were done before therapy, and at one, two and three weeks thereafter. Paired sera (obtained before treatment and again three weeks later) were tested for *M. pneumoniae* antibodies. Oral oxytetracycline for ten days was given each index case; adults: 0.5 gram q.i.d. till afebrile, then 0.25 gram q.i.d.; children: 0.05 gram/kilo each day in four divided doses, the dosage not to exceed adult levels.

In the study of the household contacts of the index cases, this plan was followed:

Throat swabs from all household members were cultured for *M. pneumoniae* before therapy and weekly thereafter for three more weeks. Serum antibodies were measured before and three weeks after the onset of therapy. Alternate families received either oxytetracycline or placebo in facsimile form. Adults were given 0.25 gram q.i.d. for ten days, while children took 0.02 gram/kilo daily for ten days in divided doses.

Whenever a family member developed sufficiently severe symptoms to cause self or parental concern and examination revealed findings compatible with the disease, he too became an index case and was treated according to that schedule.

Progress records were kept separately by physician and family and neither physician nor family was aware of the type medication provided for the family. At the termination of the study, each family turned in its record sheet providing information of illness of all members and stating its opinion as to the success or failure of the prescribed therapy.

Compilation of data was performed before the therapeutic code was examined showing which families received oxytetracycline and which were furnished placebo.

Laboratory Procedures

Complete blood counts and standard throat culture for bacteria on blood agar were obtained from each patient.

Both broth and solid media were prepared according to the formulation of Chanock, Hayflick and Barile.[5] This horse serum broth also contained 1% glucose and 0.01% phenol red. The solid medium was prepared by adding 1.5% agar to the broth without glucose or phenol red. Both media contained 1000 PPM of thallium acetate and 1000 units/ml of penicillin G.

For culturing *M. pneumoniae,* one of two swabs was placed immediately into a PPLO broth medium, the second swab was streaked onto a solid agar medium and both were incubated at 37° C. Subcultures from the broth to solid agar medium were made weekly or earlier if the pH indicator dye (phenol red) suggested that acid had been produced.

All plates were observed for at least 21 days. When colonies suggestive of *M. pneumoniae* were seen, subcultures were made and presumptive proof of identification achieved when beta hemolysis was found in an overlay of 4% guinea pig erythrocytes. Final identification was accepted when inhibition of growth was demonstrated by immune serum, or by specific fluorescent antibody staining.

Sera were obtained from almost all participants before the onset of therapy and again three to four weeks later. These sera were studied by three methods:

1. Tetrazolium Reduction Inhibition (TRI) performed in microtitration plates using the method of Senterfit and Jensen.[16]

2. Indirect Hemagglutination Assay (IHA) by the method of Dowdle and Robinson.[17]

3. Complement Fixation (CF) in microtitration plates employing antigens prepared by the method of Chanock.[18]

A positive serologic diagnosis of infection was accepted when there was a four-fold rise between samples #1 and #2.[19]

Results

Using the above described clinical criteria, we studied 136 patients from 86 families. Confirmation of the diagnosis was furnished in 79 of the 86 families; and a critical appraisal of the epidemiologic data is published elsewhere.[20]

Table I depicts the various clinical groups encountered. The largest included otitis, bronchitis, and/or pneumonia plus changes on chest roentgenograms (RG). The next largest group were those with otitis alone, followed by those with only bronchopulmonary disease. Notably absent were signs of pharyngeal involvement. Fever was an inconstant finding, and it varied directly with the severity of the other signs of disease. Incidence in males and females was almost equal. In younger children, otitis media, sometimes bullous, was often the presenting problem (Table II). This otitis proved often to be recalcitrant, requiring much antibiotic therapy. When myringotomy was needed, thin serous fluid in copious amount was usually found.

Each patient had a blood count and a throat culture for bacterial pathogens. They were almost uniformly normal. One seven-year-old boy had a polymorphonuclear leukocytosis (WBC: 29,000/cu. mm), a singular exception. He later developed follicular tonsillitis as well, even as his family developed clinical, cultural and serologic evidence of *M. pneumoniae* infection. Cold agglutinins were not studied, since several investigators have demonstrated that test to be non-specific and of value only when pneumonia is present.[8,11]

The results of bacteriologic and serologic tests for mycoplasma are reported in detail elsewhere.[20] Only thirty-seven isolations of *M. pneumoniae* were made. Thus the excellence of organism recovery achieved in a pilot study (15 of 17 patients) was not maintained. Positive serodiagnosis in 148 subjects enlarged the number considered infected to 160. Seventy percent of the infected

CLINICAL MANIFESTATIONS IN ALL INDEX CASES

	0-3 yrs.	4-12 yrs.	12 yrs.
Otitis Alone	12 (23%)	25 (31%)	3 (33%)
Otitis and Auscultatory Pneumonia	3 (5.8%)	5 (6.2%)	0 (0%)
Otitis and Radiographic Pneumonia	7 (13%)	7 (9%)	0 (0%)
Otitis and Auscultatory and Radiographic Pneumonia	20 (31%)	25 (31%)	2 (22%)
Auscultatory and Radiographic Pneumonia (No Otitis)	8 (15%)	14 (16%)	1 (11%)
Radiographic Pneumonia Alone	1 (0.5%)	3 (4%)	1 (11%)
Auscultatory Pneumonia Alone	1 (0.5%)	2 (2.5%)	2 (22%)

TABLE I

CLINICAL DISEASE PATTERNS IN VARIOUS AGE GROUPS (all patients included)

Ages	Rhinitis		Otitis		Pulmonary Signs			
(in years)					Clinical		Radiographic	
	Cases	%	Cases	%	Cases	%	Cases	%
0-3 (51 patients)	31	60	41	80	34	67	43	84
4-12 (77 patients)	39	52	58	76	45	59	63	81
over 12 (8 patients)	6	75	1	13	4	50	2	25

TABLE II

people showed clinical signs of illness. This association was closest in the youngest age group, four years and under, where 25 of the 29 (86%) seropositive youngsters were ill. In contrast, 56% of the seropositive teenagers and adults were ill. The serologic method yielding results most closely correlated with clinical illness proved to be IHA (76%) while the figures for CF were 66% and for TRI 59%.

Initial chest x-ray examinations were made on 136 patients. These were repeated weekly until normal. The abnormalities encountered deserve special attention, since characteristic patterns were seen. Pulmonary involvement was usually bilateral and interstitial, and "lobar" pneumonia was not seen. When present, consolidation was confined to small portions of a lobe or lobes. Nodular densities in the perihilar areas were a frequent finding. These nodules were often initially interpreted as being calcifications, and they persisted for weeks after pulmonary infiltration had cleared.

Various radiologists reported these sometimes subtle changes in different ways, necessitating clarification. Thus was devised a classification by which the most abnormal film of each patient might be tabulated. These were then interpreted by a single radiologist as demonstrating:

Group I. Normal findings.

Group II. Prominent bronchopulmonary markings.

Group III. Perihilar nodularity and peribronchial thickening.

Group IV. Pneumonic infiltration.

Since these groups constitute a gradation of severity, it must be understood that patients' films classified in Group IV usually also contained the characteristics of Groups II and III. It was also noted that either Group III or IV would be ordinarily identified as exhibiting "pneumonia" (Table III).

To evaluate the effect of drug therapy, a comparison was made of the clinical and laboratory expressions of disease in the family contacts (Table IV). Forty of 58 contacts given placebo became ill, while only 14 of 47 contacts taking oxytetracycline (OTC) became ill. Both groups were proved infected by laboratory methods. There were in all 122 contacts in the placebo group and 120 in the OTC group.

All index cases were treated with OTC, and the previously demonstrated efficacy of tetracycline therapy was again observed.[2,14] Clinical recovery took fewer than four days in 49 patients, four-seven days in 58 patients, but more than seven days in 13 patients. Recurrence was seen in nine patients, four from families given OTC and five from those given placebo. In 16 of the 43 placebo families, one or more of the contacts required full dosage OTC therapy for clinical mycoplasmal disease during the course of the study. Members of only two of the 43 OTC families needed such therapy.

CLASSIFICATION OF CHEST X-RAY CHANGES
(Comprised of the most abnormal film of each patient)

	Group I	Group II	Group III	Group IV	Total
Age of patient 0-3 years:	8	9	10	24	51
4-12 years:	14	12	27	24	77
over 12 years:	6	0	0	2	8
TOTAL:	28	21	37	50	136

TABLE III

INFECTION AND ILLNESS IN FAMILY CONTACTS WHO HAD COMPLETE SEROLOGY AND THROAT SWAB CULTURE

	DRUG SUPPLIED	
	PLACEBO	OXYTETRACYCLINE
Total Subjects	122	120
No. Positive	58	47
%	(48)	(39)
Reported Ill	62	39
No. Positive	40	14
%	(65)	(38)
Disease Association		
Infected & Ill/Total Infected	40/58	14/47
%	(69)	(30)

TABLE IV

Tables IV and V portray the spread of disease among family contacts of all index patients. Prevention of such spread was deemed successful in 32 of the 43 OTC families but in only 14 of the placebo families.

In Table IV, the numbers "reported ill" were compiled from the family forms provided each household, upon which each family recorded the illness experience of its household members during the time of the study. Then each family rendered its decision as to whether entire family treatment had been successful in returning its members to usual health without complications or new illnesses. These decisions provide the data for Table V's classifications, "successful" and "unsuccessful." All compilations were completed before physicians or patients learned the identities of the OTC and placebo families.

FAMILY APPRAISAL OF THERAPY IN PREVENTION OF HOUSEHOLD SPREAD

TREATMENT GROUP	SUCCESSFUL	NOT SUCCESSFUL	TOTAL
Oxytetracycline	32	11	43
Placebo	14	29	43
TOTAL	46	40	86

Chi Square = 15.1

P = 0.001

TABLE V

Comment

The foregoing data demonstrate the diversity of disease produced by *M. pneumoniae* in its spread through a community. Several members of a family may be affected in turn, and all may present different problems. The familiar expression "walking pneumonia" was descriptive of most older children and adults. Their harsh, hacking coughs always contrasted sharply with their apparent lack of toxicity. So obstructive can be the mucus in this disease that the wheezing mimics that of allergic bronchitis. The younger children more often showed otitis media, sometimes bullous, as their presenting complaint. In cases requiring myringotomy, thin serous fluid in copious amounts was usually found. During this and other epidemics, the clinical picture allowed ready recognition.

Specific culture and serological technics are necessary for confirmation of the diagnosis in *M. pneumoniae* infection. To date these methods are slow, difficult, and generally unavailable to the clinician. Material for culture should be obtained as a generous specimen of morning sputum if the percentage of organism recovery is to be good.[12]

The intra-household spread of this disease is a troublesome problem. It was rendered less so by treating all family members with oxytetracycline. It is not proposed that this procedure is *always* advisable in control of a self-limiting disease, but in selected groups it could often be helpful. It is most important that physicians be aware of the high frequency and usual epidemicity of *M. pneumoniae* infection in man. Then can it be given proper consideration in the diagnosis of respiratory disease, especially when bronchopulmonary and middle ear involvement prevail.

Acknowledgment

Special acknowledgments are due John R. Mitchell, M.D., who carefully evaluated the roentgenographic changes, Miss Barbara Locke for her untiring stenographic assistance, and the many employees of the A. P. and S. Clinic and Pfizer Research Laboratories who assisted us in collection and examination of specimens.

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About Our Cover

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X-RAY CONFERENCE

Cerebellar Hemangioblastoma

*ERICH K. LANG, M.D.**
Shreveport, La.

THIS 14-year-old colored male presented at the neurology clinic with signs of cerebellar ataxia. Symptoms of ataxia first occurred some three weeks prior but had been progressive since then. The patient was otherwise asymptomatic and there was no significant past medical history.

Physical examination revealed a well-developed colored male with normal muscle tone and muscle strength. Neurologic examination confirmed typical cerebellar ataxia. One observer had described a "cog-wheel phenomenon" when testing motor strength of the right upper extremity. however this was not confirmed by subsequent observers. A "one diopter" papilledema was recorded at the time of admission in both fundi.

Stereognosis was difficult to assess because of the somewhat low mentality of the patient. Pain, temperature and touch sensorium, however, were intact.

The laboratory findings were unremarkable apart from minimal elevation of cerebrospinal fluid protein. A few crenated red cells were found in the cerebrospinal fluid. Skull roentgenograms and chest roentgenograms were unremarkable.

Because of suspicion of a cerebellar lesion, a vertebral arteriogram was performed. The vertebral arteriogram demonstrated clusters of abnormal vessels deriving their supply predominantly from a hugely hypertrophied left superior cerebellar artery. An early and dense venous phase was observed attesting to the presence of arteriovenous shunts. The arteriographic appearance was characteristic of a hemangioblastoma (Figure 1).

A posterior fossa exploration was carried out and the diagnosis confirmed. However, the tumor could not be resected. The patient was subsequently treated to a mid-plane dose of 4,500 reps via two opposing Cobalt 60 ports. Symptomatically, the patient improved, however a follow-up vertebral arteriogram performed some 3½ months after completion of Cobalt therapy demonstrated definitive evidence of residual tumor.

Comments

The diagnosis of hemangioblastoma of the cerebellum rested in the



FIGURE 1

A selective left catheter vertebral arteriogram demonstrates a cluster of abnormal vessels over the left cerebellar hemisphere with predominant supply from the superior cerebellar artery. The telltale appearance of these hugely dilated arterial and venous structures identifies the lesion as a hemangioblastoma of the cerebellum.

* Professor and Chairman, Department of Radiology, Louisiana State University School of Medicine in Shreveport, Shreveport, La. 71106.

past on findings of surgical exploration of the posterior fossa. The diagnosis was frequently suggested by presence of lesions in the retina (von Hippel-Lindau disease). Selective vertebral arteriography permits a preoperative assessment of cerebellar tumors, particularly those presenting with a hypervascular pattern. Hemangioblastoma and certain metastatic lesions are readily identifiable on the vertebral arteriogram; thus forewarning the surgeon against inadvertent entry into one of the hypervascular spaces.

Vertebral angiography and pantopaque ventriculography vie for the leading position as a diagnostic test for assessment of lesions in the posterior fossa. The examinations should be considered complementary. Pantopaque ventriculography is primarily useful for assessment of deep-seated lesions presenting into, or displacing, the ventricular system. Vertebral angiography is of primary importance for identification of hypervascular tumors in this area. ◄

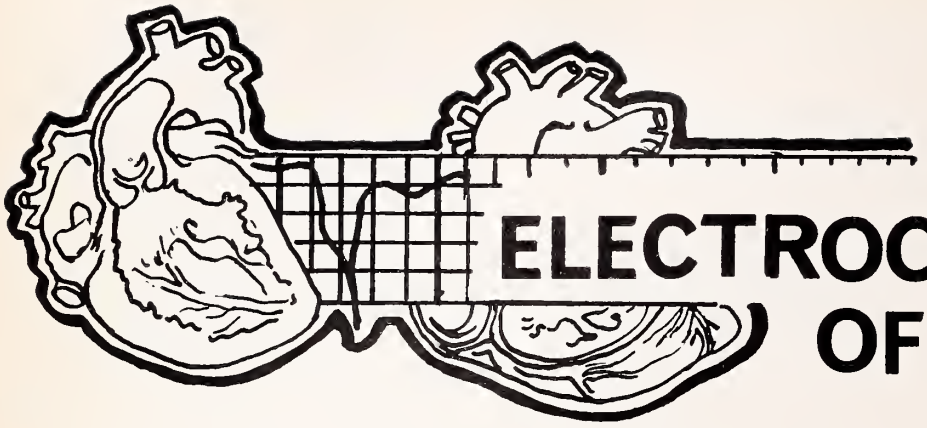
From *The Journal* 50 Years Ago

The presence of foreign bodies in the bladder is much more frequent than is commonly supposed. Probably the most common cause is a thread of cotton or linen fiber accidentally detached in drying a catheter. The writer has had at least a dozen cases of stone in the bladder where on removal the neucleus was found to be a thread of cotton or linen, and all of them were in old men dependent on the catheter for the relief of prostatic retention of urine. The cases could be practically all avoided by simply dipping the catheter in hot water immediately before it is introduced into the bladder.

Among the writer's cases of foreign body in the bladder are included one case of a large stone formed around a piece of cane pipestem, 2.50 inches in length, which the patient confessed to have introduced himself; two cases of stone formed around chewing gum which the patient also confessed to have introduced by rolling the gum into a slender piece and inserting into the meatus; also one case of stone formed around a medicated paraffin bougie, which had been introduced by the patient for the relief of chronic urethritis. . . .

On October 8, 1914, the writer was consulted by a young married woman for the relief of an extremely irritable bladder. Cystoscopic inspection showed the presence of a hairpin in the bladder, which had probably found its way there by the patient's effort to produce an abortion and by her ignorance of anatomy. . . .

Its removal was easily accomplished with a catheterized cystoscope through which was passed a medium sized urethral catheter, the end of which had been cut off and through which was passed a small piece of fulguration wire. The end of the wire was allowed to project far enough to make a very diminutive "shepard's crook" by bending it. By tilting the hook, as in adjusting a ureteral catheter, the curved end of the hairpin was easily caught by the bent wire, and on immediate removal of the cystoscope, the hairpin was removed with it. . . . W. N. Wishard, M.D., Indianapolis, "Foreign Bodies in the Bladder and the Cystoscope as an Aid in Their Removal," *JISMA*, September, 1919.



ELECTROCARDIOGRAM OF THE MONTH

Pacemaker Electrocardiography (II)

CHARLES FISCH, M.D.
*Indianapolis**

A TRACING obtained from a patient with a demand ventricular synchronized pacemaker, along with the general classification of presently available pacemakers, was presented in the August issue of this *Journal*. The accompanying ECG is that of a demand ventricular blocking pacemaker. This type of pacemaker is characterized by responding to a demand pause and suppression by spontaneous ventricular activity.

The first three QRS complexes in the accompanying figure are pacemaker induced with the second and third complex representing a fusion (combination) between the pure pacemaker initiated QRS (see last complex) and a spontaneous QRS. The first three complexes are then followed by a run of supraventricular rhythm which exceeded the preset demand rate of the pacemaker of 72 per minute and consequently suppressed (blocked) the pacemaker. The run of the AV nodal tachycardia is followed by an escape QRS and with further suppression of ventricular activity the pacemaker takes over (on demand) and initiates in the last three QRS complexes.

* From the Krannert Institute of Cardiology, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.

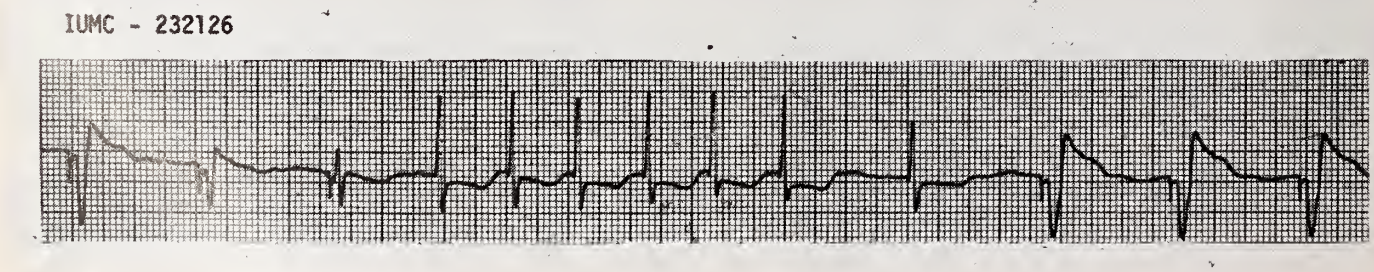


FIGURE 1
DEMAND ventricular blocking pacemaker. (For details, see text).



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A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Indication—Oral contraceptian.

Contraindications—Thrombaphlebitis, thromboembolic disorders, cerebral apoplexy ar a past history of these conditians, markedly impaired liver function, knawn or suspected carcinoma of the breast, knawn or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch far the earliest manifestatians of thrambatic disarders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfald increase in mortality and morbidity due to thromboembolic diseases in women taking oral cantraceptives. In these controlled retrospective studies, involving 36 reparted deaths and 58 hospitalizations due to "idiapathic" thrambaembalism, statistical evaluation indicated that the differences observed between users ond non-users were highly significont. The conclusions reached in the studies ore summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Categary	*Mortality Rates*		*Hospitalizatian Rates (Morbidity)*
	Age 20-34	*Age 35-44*	*Age 20-44*
Users of Oral Cantraceptives	1.5/100,000	3.9/100,000	47/100,000
Nan-Users	0.2/100,000	0.5/100,000	5/100,000

No comparoble studies are yet ovoiloble in the United States. The British data, especially os they indicate the magnitude of the increosed risk to the individuol potient, connat be opplied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medicotion pending examinotion if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledemo or retinal vascular lesions are found.

Since the safety of Ovulen in pregnoncy hos nat been demonstrated, it is recommended that pregnancy be ruled out for ony patient who has missed two consecutive periods before continuing the cantraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone ogents in oral contraceptives has been identified in the milk of mathers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and o Papanicalaou smear.

Endacrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnarmal be repeated after the drug has been withdrawn for twa months.

Pre-existing uterine fibromyamas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retentian, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthraugh bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnased vaginal bleeding.

Carefully observe patients with a history of psychic depression and discantinue the drug if severe depression recurs.

Any possible influence of pralonged Ovulen therapy an pituitary, avarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is abscure. For this reasan, diabetic patients shauld be observed carefully while receiving Ovulen.

Because of the effects of estragens on epiphyseal clasure Ovulen shauld be used judiciausly in yaung patients in whom bone growth is not complete.

The age of the patient canstitutes na absalute limiting factor, although Ovulen therapy may mask the onset af the climacteric.

The pathalagist should be informed af Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant assaciatian has been shawn between use af oral contraceptives and the following serious adverse reactions: thrambophlebitis, pulmonary embolism.

Although available evidence is suggestive of an assaciation, such a relatianship has been neither confirmed nor refuted for the fallowing serious adverse reactians: cerebrovascular accidents, neuro-acular lesians, e.g., retinal thrambosis and optic neuritis.

The follawing adverse reactians are knawn to occur in patients receiving oral cantraceptives: nausea, vomiting, gastraintestinal symptoms (such as obdominal cramps and bloating), breakthrough bleeding, spotting, chonge in menstrual flow, amenorrhea during ond ofter treotment, edemo, chloasmo or melosma, breost chonges (tenderness, enlargement, secretion), change in weight, changes in cervical erosion ond cervical secretions, suppression of lactotion when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuols, mental depression.

Although the following adverse reactions hove been reported in users of oral contraceptives, an ossociotion has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in oppetite, cystitis-like syndrome, headoche, nervousness, dizziness, fotigue, backache, hirsutism, loss of scalp hoir, erythema multiforme and nodosum, hemorrhogic eruption, itching. The following loboratory results may be oltered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulotion tests: increase in prothrombin, Foctors VII, VIII, IX ond X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.



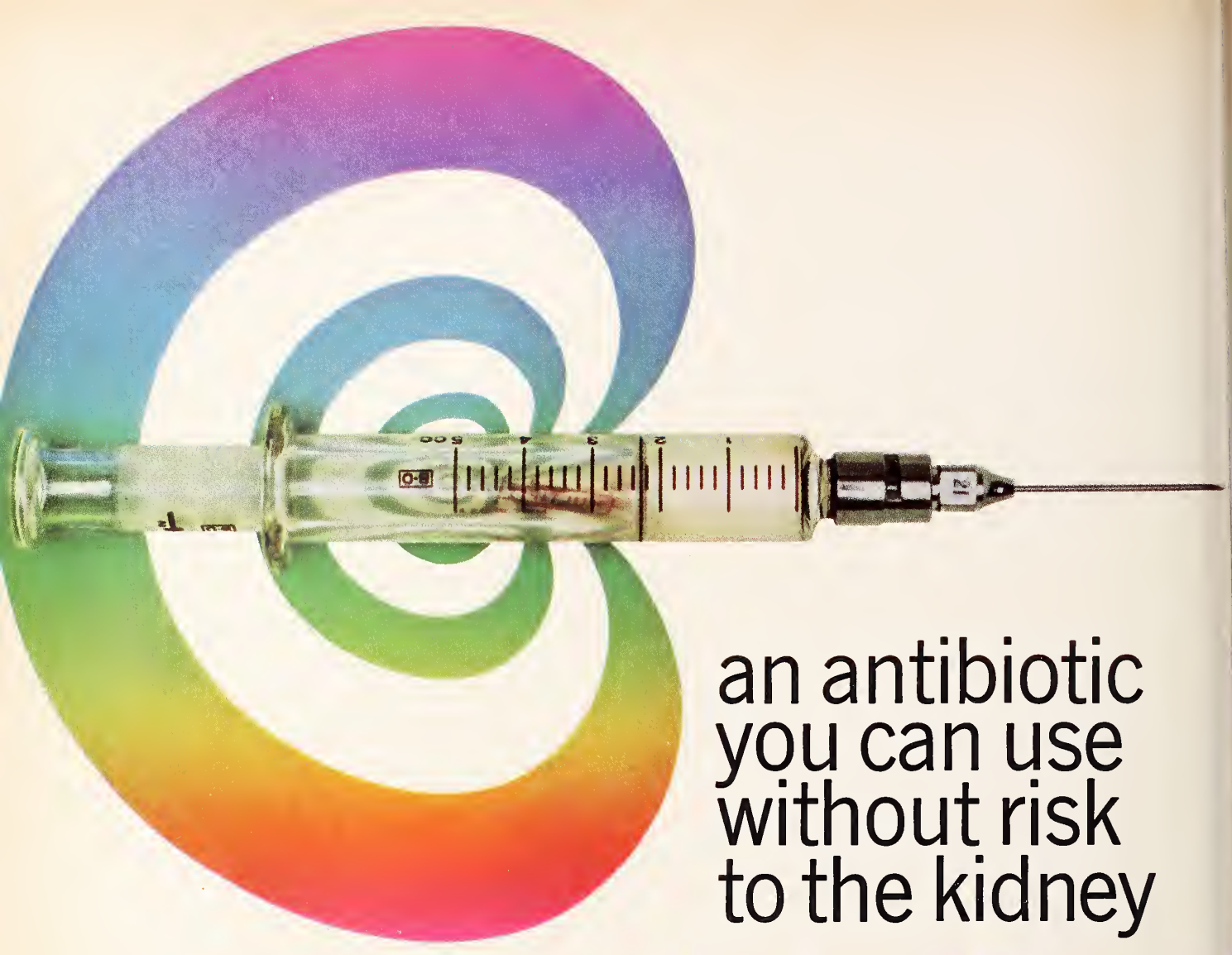
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Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.

Precautions: Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.

Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.

Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis—150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.

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Final Report of the Drug Research Board

THE Drug Efficacy Study of the National Academy of Sciences-National Research Council has been conducted with the cooperation of the FDA and of the pharmaceutical industry. And, despite the fact that some of the conclusions have been objected to by the industry, C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association, has complimented the entire massive enterprise with words of praise for the well-conceived and well-executed project.

The final report of the Drug Research Board, issued in July, commented specifically on "the unrestrained but unobtrusive cooperation of the FDA and of the pharmaceutical industry." It was the pioneering work of the PMA Commission on Drug Safety in 1962 and 1963 which was responsible for the formation of the NAS-NRC panels which comprise the Drug Research Board.

One of the important results of the study has been the recognition of the complexity of the question involving therapeutic equivalence. On this, the report says that "until recently it had been assumed that if two or more drugs met the same standards of chemical identity required by FDA they would be equally effective at the same dose. Recently, however, there have been definite indications that different brands of a few drugs in chemically equivalent formulations have given significantly different biological responses."

The PMA statement emphasizes that the biological equivalence of drugs should be carefully studied as a first order of business.

Mr. Stetler states that the PMA agrees that the manufacturers should submit, in addition to evidence of chemical equivalence and purity, data on dissolution rate and data from other in vitro tests demonstrating equivalency, and that, when there is doubt of biological equivalence, biological tests should be required.

One understandable, but seldom mentioned, circumstance brought to light for the drugs of the 1938-1962 era is that many drugs were released during that period for clinical use without what would be considered at the present time as sufficient data. This, of course, was possible because the legal and medical requirements of the time were entirely different.

The drugs which have been ruled ineffective by the research board are not only few in number (seven percent of the whole), but are also almost without exception, agents which are used but seldom today and which were not considered to be especially effective prior to the Drug Efficacy Study.

The panel comments "There is every reason to believe that industry is aware of the need for, and seeks to obtain, the best scientific endorsement of its products. The failure, therefore, must be attributed to the difficulty that industry has in commanding the needed clinical facilities and the services of experienced investigators. This is not a fault of industry alone, but rather is a reflection of a serious gap in the programming and management of the national effort in therapeutic research."

Many members of the panels concerned have expressed agreement with the suggestion that a drug compendium be published to replace package inserts. The report supports this idea but states that the compendium should be published by a responsible institution within organized medicine, in order to avoid the inference that the work would become a therapeutic "bible" supported by statutory authority.

Employment of the Handicapped

NATIONAL Employ the Physically Handicapped Week will be observed October 5 to 11.

A long editorial could be written on the subject, many more words

could be used, but it could not be said better than it was said by Thomas J. Watson, Jr., chairman of the board of the IBM Corporation—"The handicapped worker has not only shown himself to be a good and competent employee; he frequently brings something extra in the way of motivation. He tries harder because he wants to show what he can do. As a result, employment of the handicapped is no longer regarded as an act of compassion; it is a matter of good business judgment."

Three-Legged Stool Revisited

"THREE-LEGGED stool, hell" I heard the old grouch exclaim as I came into the staff lounge. I knew immediately that he was referring to the traditional triad of teaching, research and service that is supposed to encompass the activities of schools of medicine and teaching hospitals.

The speaker seemed to be complaining, as he often did, that the research leg of the stool had hypertrophied to alarming proportions in large part because of the availability of research grant monies. As he warmed to his topic, he included charges of lack of interest in student teaching by medical school faculties. By indirection, he implied that many on the faculties were more comfortable with guinea pigs and Bunsen burners than they were with medical students.

I was forced to speak up and say that these charges had been leveled before, but that it was usually necessary for medical school faculties to engage in research in order to get the funds to cover their salaries. I told him that many physicians were not only competent researchers, but also very successful teachers. Furthermore, I challenged him to offer a positive solution rather than just to criticize. I felt fairly safe in this challenge because I had never heard any viable alternative offered to the present situation.

Just as I thought that I had finally pinned him to the wall with this issue, his face lightened and he exclaimed "I do indeed have a solution, but I was afraid you'd never ask." Just as he was about to expound on the solution, he was paged by the hospital operator, but he gave his solemn pledge to reveal his solution to me at our next meeting. —J.W.H.

Editorial Notes . . .

The XYY syndrome was discussed for two days at a recent conference sponsored by the National Institute of Mental Health. The verdict is that no link between XYY and criminal behavior has been clearly established. The general impression to the contrary, as presented in the popular press, is felt by the experts to be fallacious.

The Veterans Administration is stocking a new type of nylon pajamas as part of the its fire protection program. Originally cotton pajamas treated with a heat resistant chemical were tested but laundering removed the protective factor. The nylon garments compare favorably or exceed cotton in comfort, durability, patient acceptance, washing ease and allergy reaction. An added benefit is that although three times as expensive, they last 15 times as long and are therefore considerably more economical. The VA Hospital at Fort Wayne was one of 11 hospitals in which the new pajamas were tested.

The VA, which buys $24.4 million worth of drugs for its main depot and spends $21.6 million for drugs at the hospital level, reports that it has had no losses from outdated pharmaceuticals. The drug depot stock turns over three times a year to insure potency and waste control. Hospital purchases are made with an arrangement for return of outdated and perishable items. Three VA hospitals are testing an automated pharmacy control system which may be expanded to computer programming for all 166 VA hospitals.

A small inexpensive artificial kidney is being developed by the Atomic Energy Commission. It will be suitable for home use. The size (8x2.5x2.5 inches) is small enough to operate with small blood loss. The unit may be either cleaned easily or disposed of. It is inexpensive enough to allow a patient to be dialyzed daily. It is estimated that, when perfected, the dialyzer will be applicable to 50,000 Americans annually. Between 2,500 and 3,000 patients are dialyzed each year with the present units.

The average basic operating expenditures per undergraduate medical student rose from $5,902 in 1958 to $12,841 in 1967. However, the Association of American Medical Colleges reports that only some of this increase can be legitimately charged to education of medical students. Cost factors are increased obligations for participation in health related instruction; new responsibilities for the delivery of health care; new interest in continuing education, and increased responsibility for postgraduate education of scientists and physicians.

Delirium tremens will be studied by the VA on a coordinated scale over a two-year-period. Thirty-four VA hospitals will participate. Selected male patients under age 60 who have no other serious medical and psychiatric complications will be observed for 10 days. The patients will be assigned at random to be treated with one of four drugs—Librium, Trilafon, Nembutal, and paraldehyde.

A Doppler monitoring instrument has been developed which permits a vigil on as many as ten fetal heartbeats at once. A trained operator can listen for abnormalities

in all ten patients even while performing other duties. Since the pattern of change in fetal heart rate is often more important than the actual rate, this type of monitoring is very valuable.

The 10-Gallon people are being recognized. At least 200 volunteer blood donors nationwide have given in excess of 10 gallons and will receive a special plaque of honor through their local blood banks from the American Association of Blood Banks. If the overall champion can be determined in time, he or she will be the guest of honor at the annual meeting in Houston November 18.

A survey on hospital costs in Wayne County, Michigan, as reported in the *Detroit Medical News*, shows that the two prime critics of the present method of delivering medical care, the federal government and organized labor, have fantastically high hospital costs. The VA Hospital in Allen Park has the lowest ratio of employees per patient of all the hospitals surveyed, but has a cost of $3,350 per admission (three times the cost of the most expensive open staff hospital.) They do not have a coronary care unit. Metropolitan Hospital, which was established by Walter Reuther, to demonstrate to organized medicine how medical care could be delivered at a cut rate, has the second highest cost per admission—$1,309. They do not have a coronary care unit, but they do have 5.58 employees per patient. The average cost of all closed staff hospitals in the survey was $1,197 per patient admission; the average for all open staff hospitals was under $550.

Practicing pharmacists in Indiana have been afforded, for the second year now, a continuing education in pharmacy, broadcast by television from Purdue to seven areas in the state. This year 450 individuals from 58 communities took part. The series is sponsored by Purdue and Butler Universities and the Indiana Pharmaceutical Association. The program content was determined by questioning the prospective students. Each classroom was connected to the Purdue studio by phone to allow for audience questions. All participants could hear the questions and view the discussion. Audience verdict—great show.

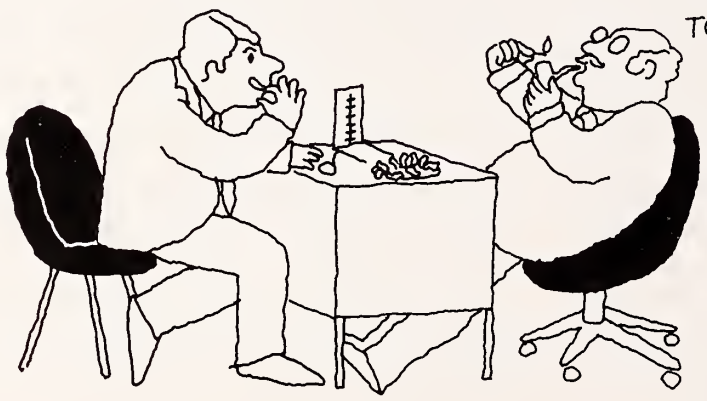
Blood donors in good health may now continue their donations until their 66th birthday. This liberalization of the old rule (no donors over 61) was made recently by the American Association of Blood Banks and the American National Red Cross. The rule change is based on two facts: (1.) More blood is needed (the need is increasing at a 12% rate annually) and (2.) Americans are living longer and are in better health and vigor.

The Commonwealth Fund and the Carnegie Corporation are combining grants of about one quarter million each to bankroll five medical schools, Duke, Case Western Reserve, Johns Hopkins, McGill and Stanford, in a collaborative program to develop physicians who are especially trained as leaders in improving the delivery and availability of health care—and to improve the opportunities for and the quality of postgraduate or continuing medical education. The first objective will be sought by introducing into the intern and resident years the assets of non-medical disciplines to produce clinical scholars who, in addition to being internists, will be prepared for community leadership. The second objective will be approached by developing concentrated courses of continuing medical education which are attractive and dynamic and the establishment of a plan whereby physicians in practice will cover for each other while they, one at a time, devote full time for a month or so in an in-residence training course in a hospital, preferably the one in which they received their initial residency experience.

Biologists at the Atomic Energy Oak Ridge Laboratory have seen and photographed, with the aid of an electron microscope, individual functioning genes. This is the first time a gene has been seen in the process of making identifiable RNA. Amphibian egg cells are used because of their large size and because genes of amphibians multiply outside the chromosomes. ◄

The Apprehensive Hypertensive



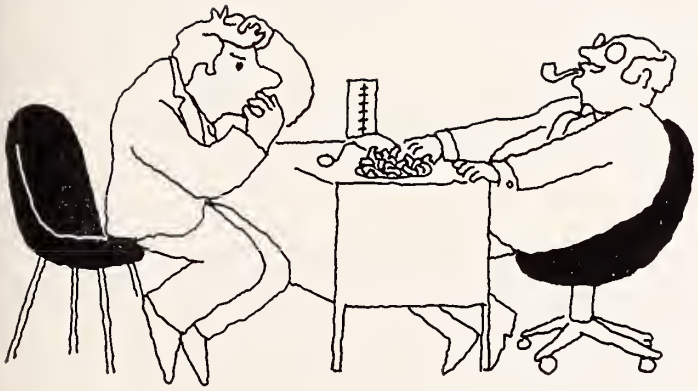


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chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

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Indications: Hypertension. *Contraindications:* History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. *Warning:* With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers. *Precautions:* Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving

WE'VE GOT TO GET PLENTY OF REST AND TRY TO AVOID SITUATIONS THAT MAKE US ANXIOUS OR TENSE. AND WE'LL TAKE MEDICINE TO LOWER OUR BLOOD PRESSURE AND CALM US DOWN.





WE'VE GOT PROBLEMS.

and allay anxiety in hypertension

corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. *Adverse Reactions:* The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. *Average Dosage:* One tablet daily with breakfast. *Availability:* Pink, single-scored tablets in bottles of 100 and 1000. (B)46-600-C

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RE-6742

The Woman's Auxiliary

REPORTS TO ISMA

As you know, the Woman's Auxiliary held their House of Delegates at the Waldorf Astoria at the same time your House of Delegates was in session at the Americana.

It is impossible to epitomize in this report the numerous auxiliary activities, but I do want to accentuate my pleasure at being able to attend as the Indiana presidential delegate.



At the opening session the entire Indiana delegation was present. We were all proud that the first order of business was the granting of an honorary membership to the National Woman's Auxiliary to Ethel Gastineau. At a later time Mrs. Burton Kintner was elected to the nominating committee and Mrs. Bruce Kephart was selected to serve as North Central Regional National Community Health Chairman.

The goals of the Woman's Auxiliary, as explained by Mrs. John M. Chenault, national president, are unique. She told us that we must work on ways to strengthen the family unit—and that anything we do should be on the basis of making individuals better family people.

Secondly she said, "One of the most important functions we can serve is in the area of information." But in order to do this effectively, Mrs. Chenault admits that the members themselves must be informed and aware of problems in their community.

Meanwhile, "Back Home in Indiana," Mrs. Rex Joseph and her committee were finalizing plans for an auxiliary day during your 120th Annual Convention. It will be Wednesday, October 15, 1969, and is as follows:

9:30 Coffee and Registration Marion County Medical Society Office
10:00 Open Board Meeting All members welcome
11:30 Leave by bus for Woodstock Country Club
12:30 Lunch at Woodstock Country Club followed by a tour of Oldfields

See you at convention!

Sylvia Schneider

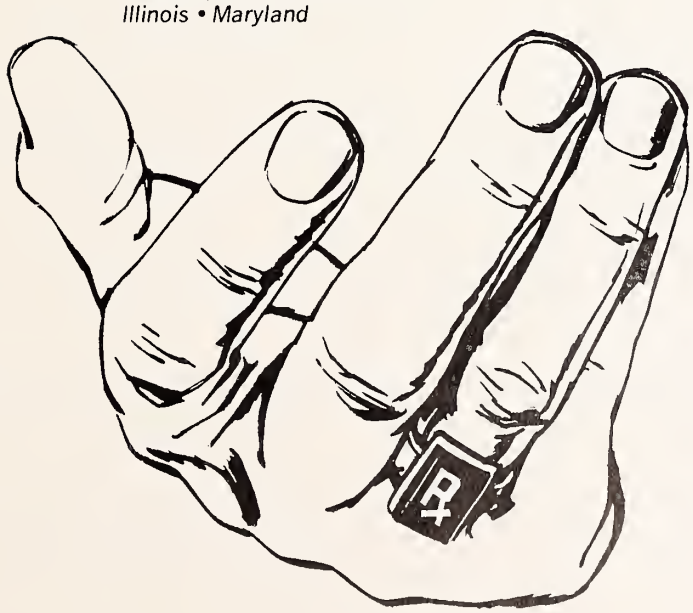
A LITTLE EXTRA SUPPORT

Because professional people deserve professional support, we at White-Haines have been keenly aware of the need for our programs and policies to be constructive and beneficial to the profession and industry. That's why we work with and support professional industry organizations and associations, including state and local meetings, publications, research foundations and numerous other activities.

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U.S. DEPARTMENT OF

HEALTH, EDUCATION AND WELFARE

Office of the Secretary

Washington, D.C. 20201

Secretary of Health, Education and Welfare Robert H. Finch has issued a new regulation limiting fees paid to physicians, dentists, and other individual providers of medical services under Medicaid.

The HEW regulation limits payments to providers participating in state Medicaid programs to those received in January, 1969, unless payments are below the 75th percentile of customary charges.

The department's action on fees became effective July 1, 1969, and remains in effect until July 1, 1970.

Secretary Finch said "HEW is determined to hold the line on medical costs." The new regulation does not cover payments for prescription drugs, nursing home services, hospital care or other services.

States whose payment structures provided payments below the 75th percentile of customary charges on January 1, 1969, may request permission from the Secretary of Health, Education and Welfare to raise payments to that level.

States whose payment structures provided fees above the 75th percentile of customary charges must adjust their payments so that they do not exceed reasonable charges as determined under Title XVIII-B of the Social Security Act (Medicare).

After July 1, 1970, states may request permission to increase fees paid to physicians and dentists only if two conditions are met:

(1). The average percentage increase requested above the 75th percentile of customary charges on January 1, 1969, may not exceed the percentage increase in the all-services component of the Consumer Price Index (adjusted to exclude the medical component) or in an alternate index designated by the Secretary of Health, Education and Welfare.

(2). Evidence must be clear that the providers and the states have cooperatively established effective utilization review and quality control systems.

Regardless of which payment level was in effect in FY 1970, in a given state, the 75th percentile of customary charges will provide the floor above which allowable CPI increases will be measured.

The new regulation requires states to revise their state Medicaid plans to include descriptions and details of their payment structures. A state that wishes to revise its payment structure for practitioners' services or change the payments authorized under it may not do so until the proposed changes have been approved by the Secretary of Health, Education and Welfare or his representative.

States that begin their Medicaid programs after July 1, 1969, must arrange their payment structures so that fees do not exceed the 75th percentile of customary charges. (Alabama, Alaska, Arizona, Arkansas, Florida, Indiana, Mississippi, New Jersey, North Carolina and Tennessee do not yet have programs. Virginia's Medicaid program begins to operate on July 1.)

The new regulation implements Secretary Finch's budgetary decision to set Federal standards for vendor payments to physicians, dentists and other medical practitioners to control escalating Federal and state expenditures for the programs.

The secretary appointed an Advisory Committee on Payments to Individual Practitioners under Title XIX, chaired by Dr. James Haughton, First Deputy Administrator of the New York City Health Services Administration to consider alternatives that would curb rising costs of payments to individual practitioners. Emphasis was to be placed on the control of future escalation.

The committee met with representatives of organizations of providers of service and drew up the regulation after full consideration of the views expressed.

120th
Annual Convention

INDIANA STATE MEDICAL ASSOCIATION

October 13, 14, 15, 16, and 17, 1969

All Events on Eastern Standard Time

Murat Temple,

Indianapolis, Indiana

Complete Program and Annual Reports on Following Pages

CONVENTION SECTION
Table of Contents

CONVENTION ISSUE (begins) 1041

OFFICIAL CALL TO THE HOUSE OF DELEGATES 1044

REFERENCE COMMITTEES 1045

HOUSE OF DELEGATES 1046

1968-69 ISMA OFFICERS 1049
- **Officers** 1049
- **Trustees** 1049
- **Past Presidents** 1049
- **Delegates to AMA** 1049

50-YEAR CLUB, 1969 1049

OFFICERS OF THE ISMA 1050
- **Board of Trustees** 1052
- **The Journal** 1053
- **Section Officers** 1054

CONVENTION ARRANGEMENTS COMMITTEES 1058

PROGRAM FOR THE 120th ANNUAL ISMA CONVENTION 1059
- **Auxiliary Program** 1069

REPORTS OF OFFICERS 1070
- **President** 1070
- **Executive Secretary** 1070
- **Treasurer** 1073
- **Chairman of the Board** 1078

District Trustees:
- First Trustee District 1078
- Second Trustee District 1079
- Third Trustee District 1079
- Fourth Trustee District 1079
- Fifth Trustee District 1079
- Sixth Trustee District 1080
- Seventh Trustee District 1080
- Eighth Trustee District 1080
- Ninth Trustee District 1081
- Tenth Trustee District 1081
- Eleventh Trustee District 1082
- Twelfth Trustee District 1082
- Thirteenth Trustee District 1083

Editor of The Journal 1083

Delegates to AMA 1083

REPORTS OF COMMITTEES:
- **Executive** 1089
  - Medical Defense 1089
  - The Journal Advertising 1090
- **Grievance** 1090
- **Student Loan** 1090
- **Medical-Legal Review** 1091
- **Future Planning** 1091
- **Sports and Medicine** 1091
- **Medicine and Religion** 1091

REPORTS OF COMMISSIONS:
- **Constitution and Bylaws** 1093
- **Legislation** 1093
- **Public Information** 1095
- **Governmental Medical Services** 1096
- **Public Health** 1096
- **Voluntary Health Agencies** 1107
- **Inter-Professional Relations** (no report)
- **Medical Economics and Insurance** 1108
- **Medical Education and Licensure** 1108
- **Special Activities** 1109
- **Aging** 1109
- **Emergency Medical Services** 1110

RESOLUTIONS 1112

SCIENTIFIC EXHIBITORS 1117

TECHNICAL EXHIBITORS 1119

Three Top AMA Officials To Visit Annual Convention

Three leading officials of the American Medical Association will visit the 120th annual convention of the Indiana State Medical Association.

Gerald D. Dorman, M.D., New York City, president of the AMA; Walter C. Bornemeier, M.D., president-elect of the AMA and Burtis E. Montgomery, M.D., chairman of the AMA Board of Trustees, will join Indiana physicians at this year's convention in Indianapolis.

A practitioner of industrial medicine, Dr. Dorman for 13 years was medical director of the New York Life Insurance Company. He has been a member of the AMA's Board of Trustees since 1960. In 1966, Dr. Dorman served as secretary-treasurer of the AMA and secretary of the association's Board of Trustees.



Born in 1903 in Beirut, Lebanon, Dr. Dorman spent the first 17 years of his life there. His father was a professor of obstetrics and dean of the school of medicine at the American University of Beirut. Following his internship in surgery at St. Luke's Hospital in New York, Dr. Dorman was in private practice of surgery until 1942 when he entered the Army as a field surgeon.

Dr. Bornemeier is a Chicago surgeon. Since 1966, he had served as speaker of the AMA's House of Delegates; he was vice-speaker for the preceding three years.



Born in Greenwood, Nebraska in 1901, Dr. Bornemeier was senior attending surgeon at Illinois Masonic Hospital from 1938 to 1967. For 20 years he was an instructor in surgery at Northwestern University Medical School, from which he had received his M.D. degree in 1929. Dr. Bornemeier will become the AMA's 125th president in June, 1970.

Dr. Montgomery is a practicing internist from Harrisburg, Ill. Born in Princeton, Ind., Dr. Montgomery interned at St. Luke's Hospital in Chicago and did part of his postgraduate work at Massachusetts General Hospital. During World War II, as commander, he served in the Navy as an assistant chief of medicine.



Dr. Montgomery was elected to the American Medical Association's Board of Trustees in June, 1966. He became chairman of the board last year and will serve until 1970. Immediate past-president of both the Illinois State Medical Society and the Southern Illinois Medical Association, Dr. Montgomery has served on the Illinois Blue Shield Plan's Board of Trustees since 1958 and is a past member of the board of directors of the National Association of Blue Shield Plans.

Telephone Service

Special telephone lines will be installed at the convention again this year. You will be paged if you have your office call you at (317) 636-1581.

Official Call to the House of Delegates

The next annual session of the Indiana State Medical Association will be held at the Murat Temple, Indianapolis, Indiana, October 13, 14, 15, 16 and 17, 1969.

The House of Delegates will be constituted as follows: Marion County, 21 delegates; Lake County, nine delegates; Allen County, six delegates; St. Joseph and Vanderburgh county societies, each five delegates; Delaware-Blackford and Tippecanoe county societies, each three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Harrison-Crawford, Jackson-Jennings, Jefferson-Switzerland, LaPorte, Madison, Owen-Monroe, Parke-Vermillion, Vigo and Wayne-Union county societies, each two delegates; the other 57 county societies, each one delegate; 13 trustees and the ex-presidents, namely, Herman M. Baker, Karl R. Ruddell, M. A. Austin, Paul D. Crimm, W. Harry Howard, Walter U. Kennedy, M. C. Topping, Kenneth L. Olson, Earl W. Mericle, Guy A. Owsley, Maurice E. Glock, Donald E. Wood, Joseph M. Black, Kenneth O. Neumann, Eugene S. Rifner and G. O. Larson, and ex-officio, the president, president-elect, executive secretary and the treasurer of the association, and the delegates to the American Medical Association, all without power to vote, except in the case of a tie vote, when the president shall cast the deciding vote.

All delegates have been certified by their county medical societies. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 10:00 a.m., Tuesday, October 14, 1969, in the Ballroom of the Columbia Club and again at 9:00 a.m., Friday, October 17, 1969, in the Ballroom of the Columbia Club.

The order of business will be as follows:

1. Call to order by the president.
2. Invocation.
3. Roll call and seating of qualified delegates.
4. Announcements from the chair.
5. Tribute to members of House who have died since the 1968 session.
6. Reading of the minutes of previous meetings.
7. Introduction of guests.
8. President's Address.
9. Appointment of Reference Committees and assignment of meeting rooms.
10. Unfinished business.
11. Address of president-elect.
12. Report of president of the Woman's Auxiliary.
13. Report of Indiana Chapter Student AMA.
14. Report of president of Blue Shield.
15. Report of executive secretary.
16. Report of treasurer.
17. Report of chairman of the Board.
18. Reports of trustees.
19. Report of *Journal* editor.
20. Report of AMA delegates.
21. Report of State Board of Medical Registration and Examination.
22. Reports of committees and commissions.

COMMITTEES:

(1) Executive
(2) Grievance
(3) Student Loan
(4) Medical-Legal Review
(5) Building
(6) Future Planning
(7) Sports and Medicine
(8) Medicine and Religion

COMMISSIONS:

(1) Convention Arrangements
(2) Constitution and Bylaws
(3) Legislation
(4) Public Information
(5) Governmental Medical Services
(6) Public Health
(7) Voluntary Health Agencies
(8) Inter-Professional Relations
(9) Medical Economics and Insurance
(10) Medical Education and Licensure
(11) Special Activities
(12) Aging
(13) Emergency Medical Services

22. New Business:

(1) Matters referred by the Board of Trustees

(2) Matters referred by the Executive Committee

(3) Resolutions

(4) Selection of city for 1974 meeting
1970 — Evansville — October 12 - 15
1971 — Indianapolis — October 11 - 14
1972 — French Lick — October 9 - 12
1973 — Indianapolis —

The election of officers will be the first order of business at the second meeting of the House of Delegates. In addition to the regular officers, the terms of the following AMA delegates and alternates expire December 31, 1969, and their successors must be elected at the session: delegates to the American Medical Association to succeed Guy A. Owsley, Hartford City, and Jack E. Shields, Brownstown; alternate delegates to succeed Maurice E. Glock, Fort Wayne, and Dwight W. Schuster, Indianapolis.

Delegates from the Second, Fifth, Eighth and Eleventh Districts are reminded that the terms of their trustees will expire October 17, 1969, and new trustees should be elected to succeed the following:

Second District—Joe Dukes, Dugger

Fifth District—Wilbert McIntosh, Riley

Eighth District—Donald R. Taylor, Muncie

Eleventh District—Lowell Hillis, Logansport

Some of these elections already may have been held, but they should be reported to the House of Delegates at this session for confirmation.

JAMES A. WAGGENER, *Executive Secretary*

Reference Committees—1969

REFERENCE COMMITTEE NO. 1:

Lowell W. Painter, Winchester (Randolph), *Chairman*
Fred Carter, LaPorte (LaPorte)
Francis Gootee, Jasper (Dubois)
W. F. Kerrigan, Connersville (Fayette-Franklin)
Walfred A. Nelson, Gary (Lake)

REFERENCE COMMITTEE NO. 2:

A. Alan Fischer, Indianapolis (Marion), *Chairman*
William G. Bannon, Terre Haute (Vigo)
Truman E. Caylor, Bluffton (Wells)
Guy B. Ingwell, Knox (Starke)
Albert S. Ritz, Evansville (Vanderburgh)

REFERENCE COMMITTEE NO. 3:

Betty Dukes, Dugger (Sullivan), *Chairman*
Lloyd L. Hill, Peru (Miami)
James F. Peck, Princeton (Gibson)
Louis F. Sandock, South Bend (St. Joseph)
Charles E. Test, Indianapolis (Marion)

REFERENCE COMMITTEE NO. 4:

Robert Seibel, Nashville (Bartholomew-Brown), *Chairman*
Lester L. Renbarger, Marion (Grant)
Hugh K. Thatcher, Indianapolis (Marion)
T. C. Tyrrell, Calumet City, Ill. (Lake)
John D. Wilson, Evansville (Vanderburgh)

REFERENCE COMMITTEE NO. 5:

Fred Smith, Jr., Tell City (Perry), *Chairman*
Fred W. Dahling, New Haven (Allen)
Thomas A. Elliott, Elkhart (Elkhart)
Richard Ingram, Montpelier (Delaware-Blackford)
Howard R. Marvel, Lafayette (Tippecanoe)

HOUSE OF DELEGATES

Indiana State Medical Association

Indianapolis—October 13, 14, 15, 16, 17, 1969

County and Delegates	Alternates
ADAMS (1)	
Norman E. Beaver, Berne	
ALLEN (6)	
Charles H. Aust, Fort Wayne	Wm. R. Clark, Jr., Fort Wayne
Fred W. Dahling, New Haven	Richard W. Emme, Harlan
Franklin F. Bryan, Fort Wayne	Ronald G. Kleopfer, Fort Wayne
DeWayne L. Hull, Fort Wayne	Jeff H. Towles, Fort Wayne
Alvin J. Haley, Fort Wayne	Edwin E. Morey, Fort Wayne
John S. Farquhar, Fort Wayne	Kenneth F. Isenogle, Fort Wayne
BARTHOLOMEW-BROWN (2)	
Harold W. Richmond, Columbus	Walter Able, Columbus
Robert Seibel, Nashville	
BENTON (1)	
Virgil Schuerich, Oxford	D. L. McKinney, Otterbein
BOONE (1)	
Don Boyer, Lebanon	Thornton Perkins, Lebanon
CARROLL (1)	
T. Neal Petry, Delphi	Carlos E. Amaya, Flora
CASS (1)	
R. H. Maschmeyer, Logansport	
CLARK (1)	
Eli Goodman, Charlestown	William R. Greene, Henryville
CLAY (1)	
Stanley Froderman, Brazil	
CLINTON (1)	
Robert A. Hedgcock, Frankfort	
DAVIESS-MARTIN (2)	
Marshall H. Seat, Washington	Robert H. Rang, Washington
Robert E. Chattin, Loogootee	Emory B. Lett, Loogootee
DEARBORN-OHIO (2)	
F. L. Frable, Lawrenceburg	Leslie M. Baker, Aurora
Gordon S. Fessler, Rising Sun	

County and Delegates	Alternates
DECATUR (1)	
Robert Acher, Greensburg	James C. Miller, Greensburg
DE KALB (1)	
John Harvey, Auburn	J. Robert Edwards, Auburn
DELAWARE-BLACKFORD (3)	
Glynn Rivers, Muncie	Jack Alexander, Muncie
Ross Egger, Daleville	Thomas M. Brown, Muncie
Richard Ingram, Montpelier	Paul E. Burns, Montpelier
DUBOIS (1)	
Francis Gootee, Jasper	Edward Ploetner, Jasper
ELKHART (2)	
Thomas A. Elliott, Elkhart	
James D. Finfrock, Elkhart	
FAYETTE-FRANKLIN (2)	
W. F. Kerrigan, Connersville	A. M. Hudson, Connersville
Perry Seal, Brookville	Elmer Peters, Brookville
FLOYD (1)	
Marshall Buchman, New Albany	
FOUNTAIN-WARREN (2)	
Max N. Hoffman, Covington	Lowell Stephens, Covington
William A. Ringer, Williamsport	Carl A. Nelson, West Lebanon
FULTON (1)	
Dean K. Stinson, Rochester	J. D. Richardson, Rochester
GIBSON (1)	
J. F. Peck, Princeton	R. E. Weitzel, Princeton
GRANT (1)	
Robert M. Brown, Marion	Barton T. Smith Marion
GREENE (1)	
Sam Rotman, Jasonville	John Woner, Linton
HAMILTON (1)	
Joseph R. Lloyd, Noblesville	A. Adrian Lanning, Noblesville

County and Delegates	Alternates
HANCOCK (1)	
Wayne H. Endicott, Greenfield	James T. Anderson, Greenfield
HARRISON-CRAWFORD (2)	
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David J. Dukes, Corydon	
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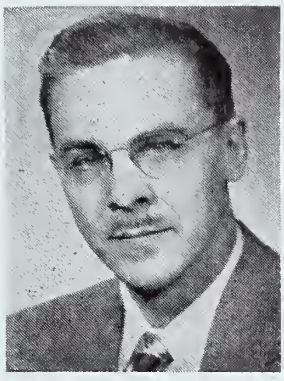
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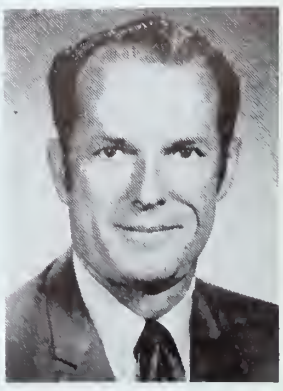
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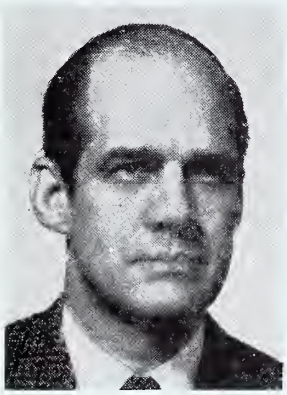


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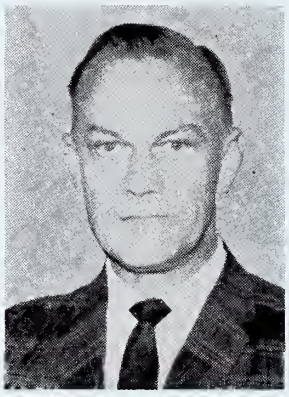
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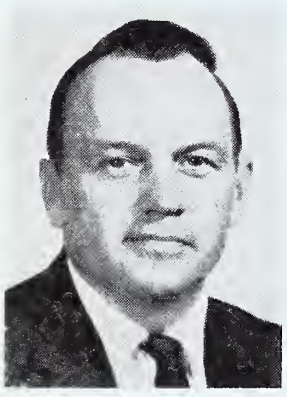
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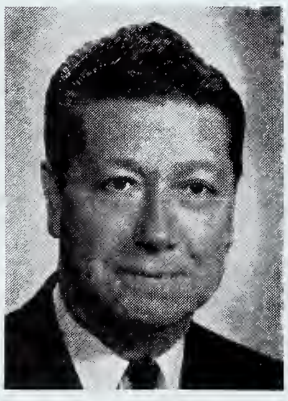
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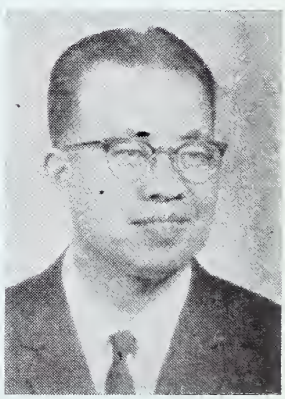
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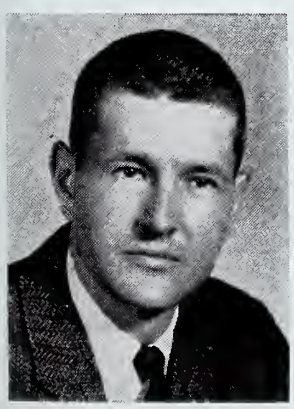
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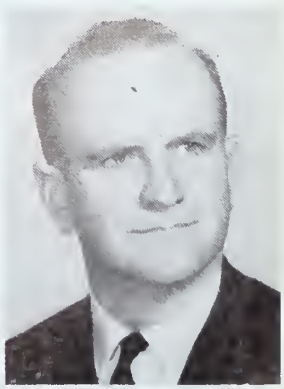
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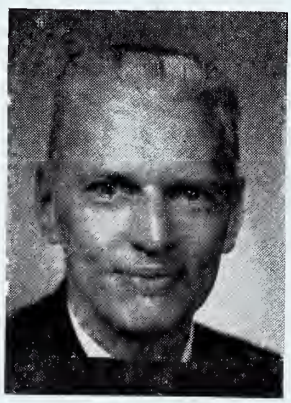


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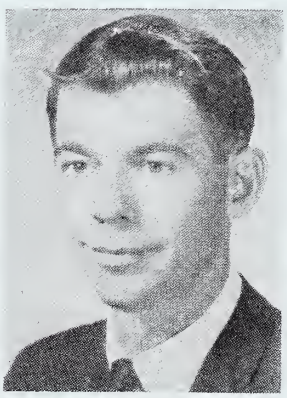


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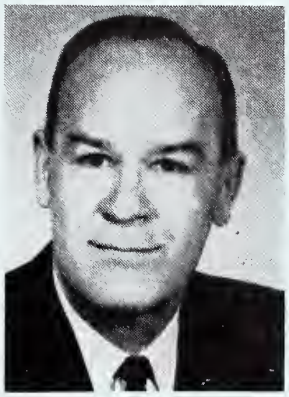


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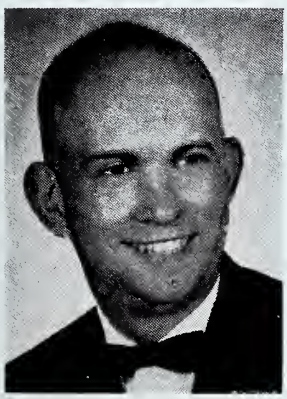


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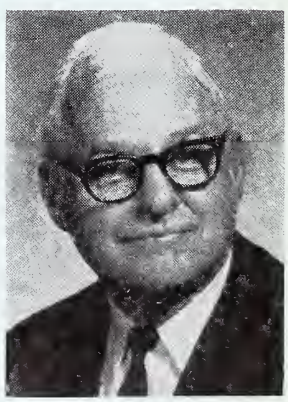
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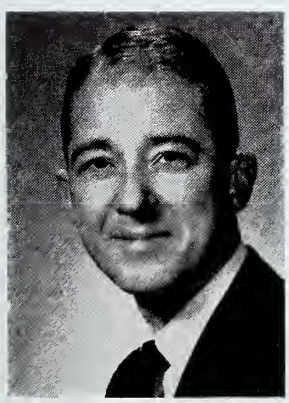


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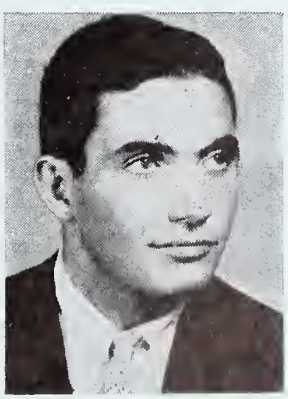


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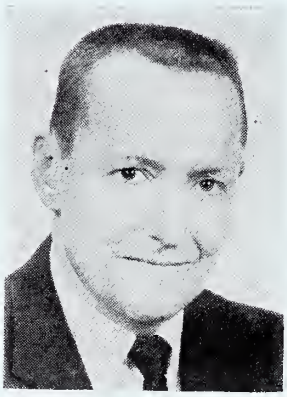


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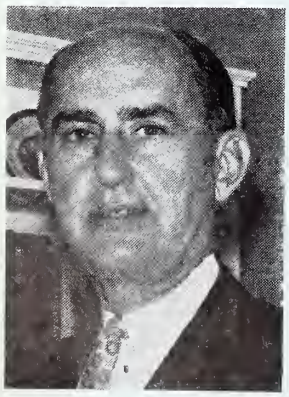


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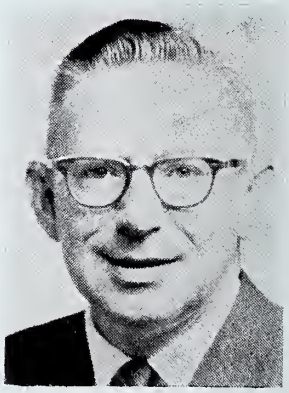
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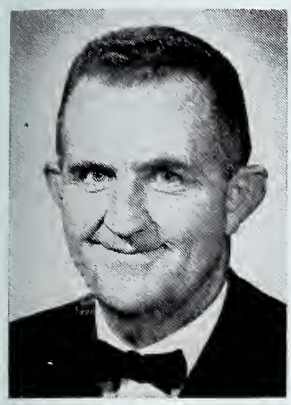
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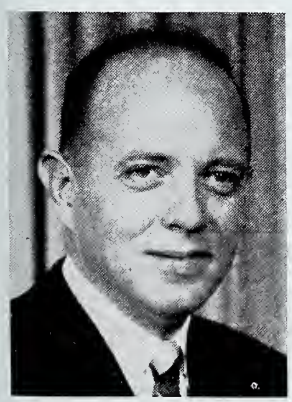


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120th Annual Convention
Indiana State Medical Association
Murat Temple, Indianapolis, Indiana

October 13, 14, 15, 16 and 17, 1969

(All Events will be on Eastern Daylight Saving Time)

(The scientific program of the 120th annual convention of the Indiana State Medical Association is acceptable for 14½ elective hours by the American Academy of General Practice).

Monday, October 13, 1969

10:00 a.m. Executive Committee luncheon meeting, Walnut Room, Columbia Club.

2:00 p.m. Board of Trustees meeting, Parlors A and B, Columbia Club.

Monday Evening, October 13, 1969

7:30 p.m. Flying Physicians Association, Indiana Chapter, meeting, Walnut Room, Columbia Club. (Not a dinner meeting).

8:00 p.m. Annual Trustees Dinner, East Ballroom, Atkinson Hotel.

Tuesday Morning, October 14, 1969

8:00 a.m. Board of Trustees breakfast meeting, Parlors A and B, Columbia Club.

10:00 a.m. Meeting of House of Delegates, Ballroom, Columbia Club.

11:30 a.m. Golf Tournament, Hillcrest Country Club, 6098 Fall Creek Road.

12 noon Registration begins, Murat Theatre lobby.

Opening of technical and scientific exhibits, Lounge Room, Murat Temple.

SECTION MEETINGS

12 noon SECTION ON PATHOLOGY AND FORENSIC MEDICINE luncheon, Blue Room, Athenaeum.

"The Regional Concept of Automation in Laboratory Medicine,"

MERRITT O. ALCORN, M.D., Madison, Ind.

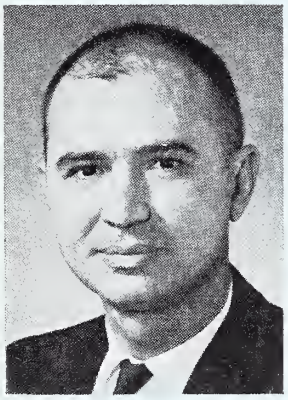
Election of Section officers for 1970.

12 noon SECTION ON SURGERY luncheon, Kellersaal, Athenaeum.

Speaker:
To be announced

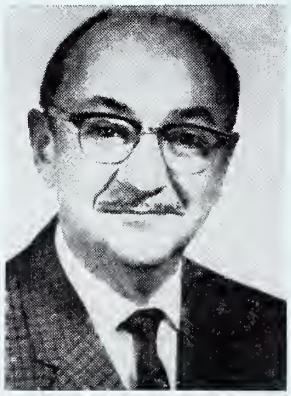
Election of Section officers for 1970.

SPEAKERS



MERRITT O. ALCORN, M.D.
Madison, Ind.

Assistant Professor, University of Louisville School of Medicine; Specialist in pathology; President, Indiana Division of the American Cancer Society; Vice-President, Indiana State Board of Medical Registration and Examination; M.D. degree from the University of Arkansas, 1950.



FRED J. ANSFIELD, M.D.
Madison, Wisc.

Professor of Surgery, Cancer Research Division, University of Wisconsin Medical School; Past President of the American Society of Clinical Oncology; M.D. degree from the University of Wisconsin, 1933.

Photo Credits

Fabian Bachrach, New York, N.Y.; Blackstone-Shelburne, New York, N.Y.; Noble Bretzman, Indianapolis; The Carleton Studio, South Bend; Clearose Studio, Princeton, N.J.; Francis O. Galbraith, Columbus, Ind.; Harrington Studio, Logansport; Nance Studio, Evansville; Leslie A. Tompsett, South Bend; Underwoods Studio, Indianapolis; Robert Young Studio, Indianapolis.

Tuesday Morning, October 14, 1969

12 noon — SECTION ON INTERNAL MEDICINE luncheon, Veterans Room, Athenaeum.

"Chemotherapy of Solid Tumors,"

FRED J. ANSFIELD, M.D., Madison, Wis.

Election of Section officers for 1970.

12 noon to 2:00 p.m. — Time allowed to view technical and scientific exhibits, Lounge Room, Murat Temple.

Tuesday Afternoon, October 14, 1969

2:00 p.m. — Reference Committee meetings, Murat Temple.

Reference Committee No. 1, Banquet Room, Basement, Murat Temple

Reference Committee No. 2, Banquet Room, Basement, Murat Temple

Reference Committee No. 3, Banquet Room, Basement, Murat Temple

Reference Committee No. 4, Banquet Room, Basement, Murat Temple

Reference Committee No. 5, Banquet Room, Basement, Murat Temple

3:00 p.m. to 5:00 p.m. — PROBLEMS IN BLOOD BANKING AND TRANSFUSION THERAPY, Egyptian Room, Murat Temple. (Sponsored by Community Blood Bank of Marion County)

Moderator: VICTOR H. MULLER, M.D., Indianapolis, Medical Director, Community Blood Bank of Marion County.

Tuesday Afternoon, October 14, 1969

3:00 p.m. SESSION FOR PHYSICIANS

"Research—Red Cell Preservation" and

"Blood and Blood Donor Reactions,"

LT. COLONEL CHARLES E. SHIELDS, M.C., Fort Knox, Ky.

"Blood Components; Transfusion Reactions; Hb Function,"

HAROLD S. KAPLAN, M.D., St. Louis, Mo.

4:00 p.m. SESSION FOR TECHNOLOGISTS

"Research in Blood Banking,"

LT. COLONEL CHARLES E. SHIELDS, M.C., Fort Knox, Ky.

"Transfusion Reactions; Quality Control,"

HAROLD S. KAPLAN, M.D., St. Louis, Mo.

"Tissue Transplantation—The Universal Donor and Blood Group Antibodies," and *"The Role of Genetics in Blood Bank Training and Practice,"*
LT. COL. FRANK R. CAMP, Jr. MSC, Fort Knox, Ky.

(All members of ISMA are invited to attend both sessions.)

Tuesday Evening, October 14, 1969

6:00 p.m. Cocktail hour and annual dinner meeting for Women Physicians of Indiana, Parlor A, fifth floor, Indianapolis Athletic Club.

Speaker:
FRANCES T. BROWN, M.D., Indianapolis,

"Tahiti and The South Seas"

SPEAKER



FRANCES T. BROWN, M.D.
Indianapolis

General practitioner; Staff member, Methodist, Community and Winona Memorial Hospitals, Indianapolis; Member of the American Academy of Pediatrics and the American Academy of General Practice; M.D. degree from the I.U. School of Medicine, 1931.

YOUR CONVENTION OFFERS:

Scientific Exhibits

———

Technical Exhibits

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Section Meetings

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50-Year Club Reception

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Scientific Meetings

———

Fraternity Meetings

———

President's Dinner

———

Golf Tournament

———

Women Physicians' Dinner

———

Orientation Meeting For New Members

———

Fireside Conferences

———

Medical-Legal Meeting

SPEAKERS



JAMES D. BEARD, Ph.D.
Memphis, Tenn.

Assistant Professor, Physiology and Biophysics, University of Tennessee College of Basic Medical Sciences; Director, Alcohol Research Center, Tennessee Psychiatric Hospital and Institute; Ph.D. degree from the University of Tennessee, 1963.



DAVID H. KNOTT, M.D.
Memphis, Tenn.

Assistant Professor, Physiology and Biophysics, University of Tennessee College of Basic Medical Sciences; Medical Director, Alcoholic Rehabilitation Unit, Tennessee Psychiatric Hospital and Institute; M.D. degree from the University of Tennessee, 1963.



DAVID R. CHALLONER, M.D.
Indianapolis

Assistant Professor of Medicine and Special Projects Officer, Department of Medicine, I.U. School of Medicine; Former Assistant Professor of Biochemistry, I.U. School of Medicine; M.D. degree from Harvard Medical School, 1961.



RICHARD C. POWELL, M.D.
Indianapolis

Associate Professor, Department of Medicine, Indiana University Medical Center; Diplomate, American Board of Internal Medicine; M.D. degree from Northwestern University Medical School, 1955.



CHARLES A. HUNTER, M.D.
Indianapolis

Professor and Chairman, Department of Obstetrics and Gynecology, I.U. School of Medicine; Director, American Board of Obstetrics and Gynecology; M.D. degree from the University of Kansas School of Medicine, 1946.

Fireside Conferences
on
CURRENT THERAPY

Tuesday, October 14, 1969, 8 p.m.

Columbia Club

Topics for Discussion

1. *Current Therapy of Alcoholism* (Circle Room, third floor)
   JAMES D. BEARD, Ph.D., Memphis, Tenn.
   DAVID H. KNOTT, M.D., Memphis, Tenn.

2. *Current Therapy of Obesity and Hyperlipemia* (Tea Room, fourth floor)
   DAVID R. CHALLONER, M.D., Indianapolis
   RICHARD POWELL, M.D., Indianapolis

3. *Current Therapy in Contraception* (Parlor C, fourth floor)
   CHARLES A. HUNTER, M.D., Indianapolis
   C. CURTIS YOUNG, M.D., Evansville

4. *Current Therapy of Cardiovascular Emergencies* (Parlor B, fourth floor)
   WILLIAM S. MULLICAN, M.D., Evansville
   EDWARD STEINMETZ, M.D., Indianapolis

5. *Current Therapy in Surgery* (Beefsteak Room, fourth floor)
   HARVEY R. BERNARD, M.D., Albany, N.Y.
   ARA V. DUMANIAN, M.D., East Chicago

6. *Current Therapy of Infectious Diseases* (Parlor A, fourth floor)
   SAMUEL SASLAW, M.D., Columbus, Ohio
   ARTHUR WHITE, M.D., Indianapolis

7. *Current Therapy of Diabetes* (Walnut Room, fourth floor)
   JOHN A. GALLOWAY, M.D., Indianapolis
   CHARLES E. TEST, M.D., Indianapolis

8. *Current Therapy in Common Neuroses* (Fairbanks Room, fourth floor)
   JOHN B. SCOFIELD, M.D., Indianapolis
   KRYSTYNA SKLENARZ, M.D., Gary

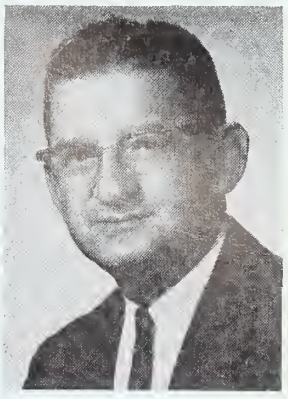
9. *Recent Advances in Cancer Chemotherapy* (Directors' Room, third floor)
   Speakers to be announced

(The Conferences are informal, unrehearsed, and provide an opportunity for free discussion of many subjects of interest to the general practitioner, as well as to the specialist. Experts will be seated at each of nine areas and physicians are encouraged to ask questions, express their own ideas, and comment on the various problems under discussion. The physicians are free to move from group to group as they wish.)



C. CURTIS YOUNG, Jr., M.D.
Evansville

Obstetrician-gynecologist; on active staff of St. Mary's and Deaconess Hospitals, Evansville; Diplomate, American Board of Obstetrics & Gynecology; M.D. degree from the University of Louisville, 1941.



SAMUEL SASLAW, M.D.
Columbus, Ohio

Professor of Medicine and Microbiology, Ohio State University; Director, Division of Infectious Diseases, Ohio State University; Diplomate, American Board of Microbiology; M.D. degree from Ohio State University College of Medicine, 1946.



WILLIAM S. MULLICAN, M.D.
Evansville

Specialist in internal medicine; Certified by the American Board of Internal Medicine; Associate of the American College of Physicians; M. D. degree from the I.U. School of Medicine, 1958.



ARTHUR C. WHITE, M.D.
Indianapolis

Professor of Medicine and Director of Infectious Disease Division, Indiana University School of Medicine; M.D. degree from Harvard University, Cambridge, Mass., 1952.



EDWARD F. STEINMETZ, M.D.
Indianapolis

Associate Professor of Medicine, I.U. School of Medicine; Specialist in cardiology and internal medicine; Director, Cardiopulmonary Laboratory, St. Vincent's Hospital; M.D. degree from the I.U. School of Medicine, 1955.



JOHN A. GALLOWAY, M.D.
Indianapolis

Assistant Professor of Medicine, I.U. School of Medicine; Director of Diabetic Service, Marion County General Hospital; Visiting physician, Marion County General Hospital; M.D. degree from the University of Nebraska College of Medicine, 1956.



HARVEY R. BERNARD, M.D.
Albany, New York

Professor of Surgery, Albany Medical College; USPHS Special Fellow in Surgery, 1964-65, St. Bartholomew Hospital, London; M.D. degree from Washington University School of Medicine, 1947.



CHARLES E. TEST, M.D.
Indianapolis

Professor of Medicine, I.U. School of Medicine; Specialist in internal medicine; M.D. degree from the University of Chicago School of Medicine, 1941.



ARA V. DUMANIAN, M.D.
East Chicago

Specialist in thoracic and cardiovascular surgery; Certified by the American Board of Surgery and the American Board of Thoracic Surgery; Former Fellow in Surgery, Mayo Foundation, 1956-1962; M.D. degree from the American University of Beirut, Lebanon.



JOHN B. SCOFIELD, M.D.
Indianapolis

Associate Professor of Psychiatry, I.U. School of Medicine; Lecturer in psychiatry, Indiana University Law School, Indiana University Graduate School; Member of the National Advisory Council, Menninger School of Psychiatry; M.D. degree from the I.U. School of Medicine, 1949.

SPEAKERS



ARTHUR L. NORINS, M.D.
Indianapolis

Professor, Department of Dermatology, I.U. School of Medicine; Certified by the American Board of Dermatology; M.D. degree from Northwestern University Medical School, 1955.



VICTOR C. HACKNEY, M.D.
Indianapolis

Professor and Chairman, Department of Dermatology, Indiana University School of Medicine; Diplomate, American Board of Dermatology; Fellow, American College of Physicians; M.D. degree from Yale University, 1943.

THE EXHIBITS

We urge you to visit with the exhibitors — they are here to help you — and to bring you the latest information. They contribute to financing your convention.

Wednesday Morning, October 15, 1969

8:00 a.m. Board of Trustees breakfast meeting, Parlors A and B, Columbia Club.

8:30 a.m. Registration continues, Murat Theatre Lobby.

Technical and scientific exhibits, Lounge Room, Murat Temple.

9:30 a.m. to 11:30 a.m. Orientation meeting for new members, Egyptian Room, Murat Theatre.

9:30 a.m. SECTION ON CUTANEOUS MEDICINE, Dermatology Outpatient Clinic, Marion County General Hospital, Indianapolis.

"Newer Concept of Immunology in Relation to Dermatology,"

ARTHUR L. NORINS, M.D., Indianapolis

Special Dermatology Clinic, VICTOR C. HACKNEY, M.D., Indianapolis, Moderator.

Clinic in association with the I.U. Medical Center and Marion County General Hospital's Department of Dermatology

Election of Section officers for 1970.

(All members of the Indiana State Medical Association are cordially invited to attend.)

10:30 a.m. SECTION ON GENERAL PRACTICE luncheon meeting, Ladies Parlors, (South) Athenaeum.

"Prospective Medicine and the Family Physician,"

LEWIS C. ROBBINS, M.D., Indianapolis

Election of Section officers for 1970.

10:30 a.m. SECTION ON RADIOLOGY luncheon meeting, Kellersaal, Athenaeum.

Election of Section officers for 1970.

10:30 a.m. SECTION ON NERVOUS AND MENTAL DISEASES luncheon meeting, East Room, Athenaeum.

"Outpatient Treatment of the Alcoholic Patient,"

DONALD W. GOODWIN, M.D., St. Louis, Mo.

Election of Section officers for 1970.



DONALD W. GOODWIN, M.D.
St. Louis, Mo.

Assistant Professor, Department of Psychiatry, Washington University, St. Louis, Mo.; Major research interest: alcoholism; M.D. degree from Kansas University School of Medicine, 1964.

11:00 a.m. SECTION ON DIRECTORS OF MEDICAL EDUCATION luncheon meeting. Kellersaal, Athenaeum.

"The Pyramid of Medical Education,"

ROBERT EVANS, M.D., York, Pa.

Election of Section officers for 1970.



ROBERT L. EVANS, M.D.
York, Pa.

Director of Medical Education and Professional Services, York Hospital, York, Pa.; Assistant Professor of Medicine, University of Maryland School of Medicine; M.D. degree from Jefferson Medical College, 1952.

11:00 a.m. SECTION ON OBSTETRICS AND GYNECOLOGY luncheon meeting, Ladies Parlors (north) Athenaeum.

"Some Aspects of Sexuality,"

LEE B. STEVENSON, M.D., Detroit, Mich.

Election of Section officers for 1970.

11:00 a.m. SECTION ON PEDIATRICS luncheon meeting, Auditorium Room, Athenaeum.

"Disturbances in Growth in Children,"

JAMES C. WRIGHT, M.D., Indianapolis.

Election of Section officers for 1970.



LEE B. STEVENSON, M.D.
Detroit, Mich.

Associate Physician, obstetrics-gynecology, Henry Ford Hospital, Detroit, Mich.; Consultant in Maternal Health to the Michigan Department of Public Health; M.D. degree from the University of Illinois College of Medicine, 1946.

11:00 a.m. Editorial Board meeting, Kellersaal, Athenaeum. (Luncheon 12 noon).

11:00 a.m. to 12 noon Time allowed to view technical and scientific exhibits, Lounge Room, Murat Temple.

12 noon SECTION ON ANESTHESIOLOGY luncheon meeting. Directors' Room, Athenaeum.

"The Anesthesiologist: Staff and Hospital Relationships,"

MURWYN L. HICKS, M.D., Indianapolis

Election of Section officers for 1970.



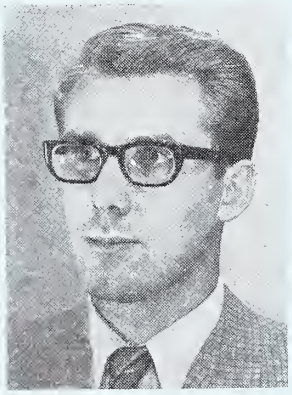
MURWYN L. HICKS, M.D.
Indianapolis

Assistant Professor of Anesthesiology, I.U. School of Medicine; M.D. degree from the University of Iowa College of Medicine, Iowa City, 1944.



A. C. OFFUTT, M.D.
Indianapolis

State Health Commissioner; Secretary, Indiana State Board of Health; Specialist in public health; M.D. degree from the Indiana University School of Medicine, 1940.



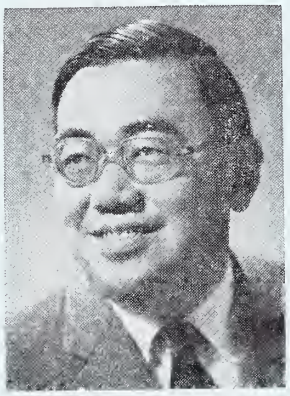
ROBERT E. WRENN
Indianapolis

From Momence, Ill.; Class of 1971, Indiana University School of Medicine.



ELIOT CORDAY, M.D.
Los Angeles, Calif.

Associate Clinical Professor of Medicine, UCLA School of Medicine; Attending physician, Cedars-Sinai Medical Center; National Consultant in Cardiology to the Surgeon General of the Air Force; M.D. degree from the University of Alberta School of Medicine, 1940.



DAVID YI-YUNG HSIA, M.D.
Chicago, Ill.

Professor and Chairman, Department of Pediatrics, Loyola University-Stritch Medical School, Hines, Ill.; Certified by the American Board of Pediatrics; M.D. degree from Harvard Medical School, 1948.



WALTER ABLE, M.D., J.D.
Columbus

General practitioner; Editor, Lawyers' Medical Cyclopedia; Member of the Indiana Bar Association; Formerly with the U.S. Public Heath Service (Indian Service); M.D. degree from the I.U. School of Medicine, 1956.

12 noon — SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE luncheon meeting, Blue Room, Athenaeum.

"The Local Health Department and the Delivery of Health Services,"

ANDREW C. OFFUTT, M.D., Indianapolis.

Election of officers for 1970.

GENERAL MEETING

Egyptian Room, Murat Temple

1:30 p.m. — Call to order by Patrick J. V. Corcoran, M.D., Evansville, President, Indiana State Medical Association.

1:30 p.m. — *"Enzymatic Basis for Cancer Chemotherapy,"*

ROBERT L. FORSTE, Indianapolis (Student)

1:45 p.m. — *"Recent Advances in Antibiotic Therapy,"*

SAMUEL SASLAW, M.D., Columbus, Ohio

2:15 p.m. — *"Recent Advances in Surgery,"*
HARVEY R. BERNARD, M.D., Albany, N. Y.

2:45 p.m. — *"Method of Routine Examination of the Cardiac Conduction System and Cases of Forensic Interest,"*

ROBERT E. WRENN, Indianapolis (Student)

3:00 p.m. — Intermission

3:15 p.m. — *"Recent Advances in Cardiovascular Therapy,"*

ELIOT CORDAY, M.D., Los Angeles, Calif.

Wednesday Afternoon, October 15, 1969

3:45 p.m. — *"Management of Some Genetic Defects,"*

DAVID YI-YUNG HSIA, M.D., Chicago, Ill.

4:15 p.m. to 5:00 p.m. — Time allowed to view technical and scientific exhibits, Lounge Room, Murat Temple.

Wednesday Evening, October 15, 1969

5:30 p.m. — Meeting of Fifty Year Club, Circle Room, Columbia Club, third floor.

5:30 p.m. — Social hour for Phi Chi Fraternity, Parlor B, Columbia Club, fourth floor.

Social hour for Phi Beta Pi Fraternity, Walnut Room, Columbia Club, fourth floor.

Social hour for Nu Sigma Nu Fraternity, Parlor A, Columbia Club, fourth floor.

6:00 p.m. — President's Reception, Third Floor Dining Room, Columbia Club.

7:00 p.m. — President's Dinner, Ballroom, Columbia Club.

Presiding officer: Patrick J. V. Corcoran, M.D., President, Indiana State Medical Association.

Invocation: MONSIGNOR MAURICE EGLOFF, Evansville

Recognition of Fifty Year Club Members.

Response: PIERCE MAC KENZIE, M.D., Evansville.

Presentation of Mental Health Award.

Presentation of Public Relations Awards.

Presentation of Scientific Exhibit Awards.

Entertainment: North High School Choir, Evansville.

Thursday Morning, October 16, 1969

8:00 a.m. — Board of Trustees breakfast meeting, Parlors A and B, Columbia Club.

8:30 a.m. — Registration continues, Murat Theatre Lobby.

Technical and scientific exhibits, Lounge Room, Murat Temple.

GENERAL MEETING

Egyptian Room, Murat Temple

9:00 a.m. to 12:00 a.m. — MEDICAL-LEGAL SYMPOSIUM

Walter Able, M.D., Columbus, Moderator (General Practitioner and Attorney)

9:00 a.m. to 10:30 a.m. — *"Medical Legal Problems Both in Aspect of the Plaintiff and Defendant,"*

LAWRENCE A. JEGEN, III, Professor of Law, Indiana University, Indianapolis Law School, Indianapolis.

10:30 a.m. — Intermission

10:45 a.m. to 11:15 a.m. — *"The Tax Reform and You,"*

CLEON FOUST, Dean, Indiana University Law School, Indianapolis



LAWRENCE A. JEGEN, III, L.L.M.
Indianapolis

Professor of Law and former Associate Dean at Indiana University School of Law; Chairman of the Tax Section of the Indiana State Bar Association; member of the Indiana Corporations Survey Commission; Counsel to the Indiana Commission on Medical Education.



CLEON H. FOUST, J.D.
Indianapolis

Dean and Professor of Law, Indiana University Indianapolis Law School; Former Attorney General of Indiana, 1947-49; J.D. degree from the University of Arizona, 1933.

SPEAKERS



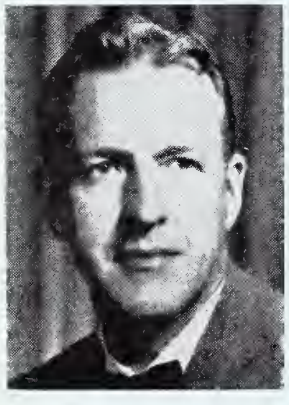
ROBERT J. CATES
Indianapolis

From Carmi, Ill.; Class of 1971, Indiana University School of Medicine.



H. F. FRASER, M.D.
Indianapolis

Specialist in clinical pharmacology; Formerly Professor, Department of Psychiatry, Emory University School of Medicine; Winner of the Public Health Service Meritorious Service Medal in 1962; M.D. degree from Cornell University Medical College, 1932.



HAROLD E. KLEINERT, M.D.
Louisville, Ky.

Specialist in hand surgery; Professor of Surgery, University of Louisville School of Medicine; Associate Professor of Surgery, I.U. School of Medicine; M.D. degree from Temple University, 1946.



EDWARD A. TYLER, M.D.
Indianapolis

Specialist in child psychiatry; Professor of Psychiatry, I.U. School of Medicine; Organizer and instructor of one of the very few required sex education courses for medical students existing in the United States; M.D. degree from the University of Virginia School of Medicine, 1944.

Thursday Morning, October 16, 1969

11:15 a.m. to 11:30 a.m. — *"The Dollar and Sense Existence of Malpractice Insurance,"*

KENNETH W. MOELLER, Medical Protective Company, Indianapolis.

11:30 a.m. to 12:00 noon — Question and answer period.

12 noon — Past Presidents luncheon, Directors' Room, Athenaeum. G. O. Larson, M.D., *Chairman.*

12:00 noon — COLLEGE HEALTH PHYSICIANS luncheon, Blue Room, Athenaeum.

Thursday Afternoon, October 16, 1969

1:00 p.m. — Small County Delegates meeting, Foyer to Candidates Room, Murat Temple.

GENERAL MEETING

Egyptian Room, Murat Temple

1:30 p.m. — Patrick J. V. Corcoran, M.D., Evansville, president, Indiana State Medical Association, presiding.

"Proteolysis of Thyroglobulin,"
ROBERT J. CATES, Indianapolis (Student)

1:45 p.m. — *"Managing the Patient Who Takes Drugs,"*

H. F. FRASER, M.D., Indianapolis

2:15 p.m. — Speaker:
To be announced.

2:30 p.m. — *"Management of Acute Hand Injuries,"*

HAROLD KLEINERT, M.D., Louisville, Ky.

3:00 p.m. — Intermission

3:15 p.m. — *"Election Microscopic Studies of Myelination,"*

GLENN J. BINGLE, Indianapolis (Student)

Thursday Afternoon, October 16, 1969

3:30 p.m. *"The Patient with the Sex Problem,"*

EDWARD A. TYLER, M.D., Indianapolis

4:00 p.m. Time allowed to view technical and scientific exhibits, Lounge Room, Murat Temple.

Thursday Evening, October 16, 1969

Murat Theatre

8:30 p.m. Entertainment—Indianapolis Symphony Orchestra

Open to all members and their guests.

Friday Morning, October 17, 1969

8:00 a.m. Board of Trustees breakfast meeting, Parlors A and B, Columbia Club.

9:00 a.m. Final Meeting of House of Delegates, Ballroom, Columbia Club.

Election of officers.

Meetings of Board of Trustees and Executive Committee immediately following adjournment of House of Delegates.

Auxiliary Program

Tuesday, October 14, 1969

9:00 a.m. to 5:00 p.m. Registration, Murat Theatre Lobby.

Wednesday, October 15, 1969

9:00 a.m. Registration continues, Murat Theatre Lobby.

9:30 a.m. Coffee—Marion County Medical Society Office, 211 North Delaware Street.

10:00 a.m. Open Board Meeting—211 N. Delaware Street (All members welcome).

11:30 a.m. Leave by bus for Woodstock Country Club.

12:30 p.m. Luncheon—Woodstock Country Club—1301 W. 38th Street.

Tour of Oldfields.

4:00 p.m. Leave by bus for downtown.

6:00 p.m. President's Reception, Third Floor Dining Room, Columbia Club.

7:00 p.m. President's Dinner, Ballroom, Columbia Club

Entertainment: North High School Choir, Evansville.

Thursday, October 16, 1969

9:00 a.m. Registration continues, Murat Theatre Lobby.

8:30 p.m. Entertainment—Indianapolis Symphony Orchestra, Murat Theatre.

Reports of Officers

Report of the President

The major objectives which I have sought were:

1. *Involvement of all eligible doctors in ISMA.* I have written to each non-member doctor in the state inviting him to affiliate with ISMA. There should be relevant activity for every segment of the profession, effective responsiveness to all of our members, projects which benefit the members and the public, and cooperation with other medical organizations with a joint annual meeting for all as an ultimate goal.

2. *Rapport with students and teachers of medicine.* We have made definite progress. One good project is a "retreat"-type meeting for students, faculty, and practicing physicians. Another is the participation of SAMA in as many phases of our activities as is practical.

3. *Dialogue with the public sector.* This has been cultivated at every opportunity. Particular care was devoted to liaison with all public officials at every level. The major effort was the appointment of an Advisory Committee on Health Care, made up of fellow Hoosiers. I will have a report to present to the House on this significant undertaking.

4. *Cooperation with hospitals and with third parties.* More understanding has been developing as a result of joint meetings devoted to candid, honest exposition of problems and differences. One big step was the meeting for chiefs of staff, administrators and hospital trustees sponsored by IHA and ISMA in September.

5. *Coping with the health manpower shortage.* This relates to continuing education and maintaining a contemporary professional posture, reassessment of our capabilities and our limitations, managing the paper load, and delineation of the roles of ancillary and allied health workers.

* * *

The first portion of the year's work was preempted by the session of the legislature. This required uncounted man hours of work by officers, the Commission on Legislation, staff and many members. The results from our standpoint were most satisfactory.

The Conference of Medical Society Officers in March was productive. Our new Commission on Emergency Medical Services has already accomplished a great deal. One result is the plan to erect a series of emergency medical highway signs as a pilot project. A course in sports health medicine was conducted early last month at the medical center sponsored by our new Committee on Sports and Medicine. An ad hoc committee reported to the Board on its evaluation of some problems in the Department of Mental Health; the findings were offered to the governor. A cooperative program among the directors of the Student Health Services of our major universities has been initiated. This is only in its formative stages, but, in my opinion, has great merit and very real potential.

Innumerable achievements—some large, and many small—have been attained; much is routine, but it would be evident if it had not been unobtrusively done.

The Board of Trustees, commissions, and committees have worked diligently. Their reports, which you will receive, contain valuable data and many stimulating ideas for consideration.

RECOMMENDATIONS

The President's Page from *The ISMA Journal* for November, 1968 and for May, June, and July, 1969, are included as a part of this report. The recommendations therein are offered for your consideration. Some of the programs advocated are (a) Professional Standards Committees; (b) making local and district societies congruent with actual medical service areas in place of the present political geographic areas; (c) promoting cooperation among all medical professional organizations, particularly by coordinating staff work, sharing facilities, and integrating their annual meetings with ours; (d) reappraisal of relationships of fees and regular revisions as needed, and (e) dealing with the growing paper load.

I recommend the formation of a new Section of College Health Medicine.

The ever-increasing exposure of medical practice to legal hazards has an urgent priority. I believe the most practical measure to consider would be to adapt the concept of workmen's compensation benefits so as to apply comparably to mishaps occurring during medical care. I urge the House to authorize the Medical-Legal Review Committee and the Commission on Legislation to develop suitable measures to present to the Board of Trustees in preparation for the next session of the legislature.

I suggest that the House consider establishing a Committee on the Good of the Association. It would be elected by the House to serve during the interval between annual meetings and would report back to the House. It would have a mandate to observe, to study, and to investigate any phase of association activity which might attract its interest. Ideally, it should include no current officer. It would function in so-called Ombudsman fashion within wide ranging limits.

Many other suggestions which I endorse are embodied in reports from the commissions.

I thank the many members who have given suggestions, counsel, admonitions and assistance. I have invariably encountered gracious cooperation and heart-warming friendliness from all the membership. It has inspired me and sustained me. I am grateful to you for having entrusted the presidency to me. On the whole, it has truly been a happy experience. My best efforts will continue in the service of ISMA.

PATRICK J. V. CORCORAN, M.D.,
President

Executive Secretary

Gentlemen:

In submitting an annual report it is always somewhat difficult since the affairs of the association extend in many directions; involving the Executive Committee, the Board of Trustees, the commissions, the various subcommittees of these official bodies and the staff.

Throughout recent years of activity the major emphasis of the association, it would appear, has been in the areas of legislation, medical licensure and medical education and socio-economic-political affairs, which deal directly with the profession in Indiana, and especially with the individual physician, as these matters affect his individual practice. Included has been a continuing concern with Medicare, Medicaid and health insurance. We feel that these activities are important, will continue to be so, and will need constant surveillance by the profession.

In my report to the association this year, however, I would like to place emphasis upon the activities of the association's various commissions, which have dealt with problems, in some instances not directly related to the individual physician's practice, but which are directly related to the health problems and needs of Indiana and your patients. In addition, I would like to report some of the innovative and imaginative programs which are under study by the commissions, and which in many instances are concerned with the individual physician's practice as well as patient care. With this brief preamble I submit to you in brief form singular highlights of each commission's total activity which must in the final analysis reflect upon the public relations and image of your association.

Scheduled appearances throughout the state before local groups such as Kiwanians, Elks Clubs, Rotarians, church groups, and professional organizations by the president of the association is being recommended by the Commission on Public Information. Definitely a public relations program, this gives local citizens throughout Indiana an opportunity to meet the president and to hear from him personally concerning the attitudes and philosophies of ISMA today. So often the public and your patients are recipients of third or fourth hand information. Such visitations would do much to correct these erroneous and false concepts.

Pre-trial discussions to avoid malpractice suits were encouraged by the Commission on Inter-Professional Relations in cooperation with the Indiana State Bar Association. The Bar Association has shown interest in developing a program of cooperation and this matter is being pursued in greater depth by the Commission on Medical Economics and Insurance and the Medical-Legal Committee.

Medical, lay and professional workers and leaders in voluntary health agencies' activities throughout Indiana continue to work cooperatively with the Commission on Voluntary Health Agencies. This commission has provided a format for greater understanding between these state groups which have in their organizational structures the leadership of people who guide the socio-political-economic attitudes of Indiana citizens who are the profession's patients. The Commission on Voluntary Health Agencies will climax their year by initiating the annual convention through a cooperative two-day program with the American Medical Association's Council on Voluntary Health Agencies. Approximately 12 states will participate. Leaders of voluntary health agencies throughout the state and nation will attend.

An ISMA Speakers Bureau is now being organized by Commission on Medical Education and Licensure. Serving on this bureau will be officers of the association, speakers of pharmaceutical manufacturing companies, and individual physicians. The bureau may be utilized by county medical societies, lay groups, students, and other professional organizations. Subjects will be listed and will involve many areas of interest. One physician has listed his subject as "Medicine in Central Indiana-Rural-Nineteenth Century." Another good public relations program start.

Malpractice problem in Indiana is being studied intently by the Commission on Medical Economics and Insurance. A package program of many insurances for the membership is in the offing. Careful scrutiny and study is being given to every phase of the malpractice insurance project and may well result in another excellent and timely service for member physicians of ISMA.

Sex education in the schools of Indiana has been of primary concern to the Commission on Public Health. This commission is urging a stand by the profession in Indiana which encourages more active participation by physicians in local planning. It's this commission's feeling that sex education is a part of medical practice, and has been so, limitedly, in the past. The commission feels there is a need for organized medicine to become more active in planning for courses and instructors.

A physician is needed to guide and direct medical staff and facilities in Indiana's prisons and reformatories. The Commission on Governmental Medical Services continues to support this concept, which has been a policy of ISMA for years, with every effort of achieving such a plan meeting with defeat. Perhaps with continued perseverance this may be achieved. It's a matter which gets little or no attention from the public press, unfortunately.

Problems of the Legislative Commission come naturally. Each biennium they are faced with reviewing hundreds of bills which deal with the health and safety of Indiana's citizens. This commission has a heavy schedule of work every biennium and meets its responsibilities with vigor. The Indiana State Board of Health, the Indiana University School of Medicine, other professional associations and voluntary health associations look to them for guidance and support.

Problems of foreign medical students occupied much of the Commission on Special Activities' time. Dr. Antonio Donesa, secretary, National Foreign Graduate Association, met with this group to inform them of the association's activities and to contribute to the commission's discussion. At this meeting a number of misunderstandings were cleared. Many commissions have accomplished similar goals throughout the year. It is one of the unpublished accomplishments of every commission at one time or another.

That limitation of earnings for the aged inhibits healthful and enjoyable activity and promotes a negative outlook is a position taken by the Commission on Aging. Dr. George E. Davis, executive director of the Indiana Commission on the Aging and Aged, met with the commission throughout the year and endorsed the concept. The problems of the aging continue to grow and this commission finds itself with an increasing amount of activity annually.

Plan for the design and establishment of directional highway route markers to emergency facilities was achieved by the Commission on Emergency Medical Services. The United States Department of Transportation has given approval for the association to proceed with the pilot study of use of these signs in a ten-county area of northeast Indiana. Funding is the problem now and the commission is making efforts to secure funds so they might proceed. The public relations value of this program is obvious. A story released by the association received wide comment from throughout the state and the plan has captured national attention.

Merging of all medical organizations into a single federation under the ISMA is being endorsed by the Future Planning Committee. The committee supports the idea of a continuing study in this area and is planning to proceed with the idea, if the House of Delegates approves. What will eventually happen is anybody's guess, but this commission, charged with the responsibility of future plans, is thinking ahead. The merger may eventually come about.

Newly activated Commission on Sports and Medicine, in cooperation with the Indiana University School of Medicine, sponsored and participated in a special one day postgraduate course on "Sports Medicine for the Physician." Among subjects discussed were pre-school conditioning, nutrition facts and fallacies, head and neck injuries, heat exhaustion, knee injuries and others. Participating with them were coaches and directors of athletics.

In addition, our officials, commission members and staff have been involved in the following programs and activities which I will not elaborate upon:

1. Preceptor Program
2. Orientation for New Members Program
3. Annual County Society Officers Conference
4. Journalism Award Program
5. Indiana Youthpower Conference
6. Annual Convention Planning
7. Three Day High School Health Program
8. Thirty Minute Film on Preceptorships
9. Cooperative Program with Indiana Public Health Association
10. Comprehensive Health Planning
11. Supervision of Indiana State Medical Association Field Service

12. Washington, D.C., Legislative Contact Trips
13. Continued Contacts with State Legislators
14. OCHAMPUS Claims Review and Payment
15. Collection of Dues
16. Maintenance of Membership Files
17. Meetings of the Board of Trustees
18. Meetings of the Board's Subcommittees
19. Meetings of the AMA
20. Special Projects of the Board of Trustees
21. Special Projects and Meetings of the President
22. Press Interviews and Releases
23. Provision of Materials and Literature to Groups, Teachers, Students and Physicians
24. Meetings with Student AMA
25. Maintenance of Building
26. Direction of Staff
27. Meetings with Committees of Allied Health Groups
28. Meetings of Student Loan Committee
29. Meetings of Grievance Committee
30. Political Action Committee Meetings

These then are just a few of the highlights of the year's work by some of the commissions and a listing of some of the additional activities. Some commissions met more often than others. Some were better attended than others. But behind each accomplishment was considerable contribution of time and interest by participating physicians.

So often the statement is made that nothing is being done by the ISMA, but as your executive secretary, I feel that much is being accomplished in many areas which are given little or no notice by the general membership.

These activities and accomplishments are necessary to the continued growth of ISMA as a strong contributing organization to health needs and demands. My wish, and I know I express the feelings of our officers, is that when a member accepts a responsibility with a commission that he attend and contribute to its proceedings and assist in developing positive action programs from commission recommendations.

I would like to add, too, that every activity involves the work and support of the staff, who assist in researching projects for commissions, planning proper meeting facilities, making additional special arrangements, and contributing in every way possible to the needs of each committee and commission.

Membership—Your secretary believes an analytical report of the membership of the association showing the trends might be of interest to the House. I realize that statistics are boring but I know of no other way that figure presentation can be made.

While the association has continued to grow in membership, the net growth has been extremely small and the projection made in 1960 by Indiana University which projected a need for 6,000 practicing physicians in Indiana by 1970 is far from being met. Many groups have discussed the retention problem of physicians. Many small communities are seeking physicians and at the present time we are unable to supply the apparent need for physicians in our state.

Your secretary believes this is a matter which should be of concern to the association and would like to suggest that a study be made of the possibility of a continued advertising campaign in densely populated areas to determine if physicians from other areas might be enticed into the state.

At the present time, based on 1967 figures, we have one patient care physician for each 1,097 individuals. If we add to this figure the total of all physicians, those who are providing patient care and those who are in research, administrative work, etc., it brings our average down to one physician for each 999 people. In 1965 our ratio of patient care physicians to population figured one physician to each 1,091 people, so on this basis, it is indicative that physician supply is not keeping pace with the population growth of our state.

Listed below, for your information, is a comparison in practice changes between the year 1964 and 1967 of the various specialty groups, including general practitioners.

SPECIALTY	1964	1967
General Practice	1835	1772
Medical Specialties (Total)	628	663
Allergy	15	17
Cardiovascular	16	19
Dermatology	43	48
Gastroenterology	1	1
Internal Medicine	376	396
Pediatrics	153	165
Pediatric Allergy	1	0
Pediatric Cardiology	2	1
Pulmonary Diseases	21	16
Surgical Specialties (Total)	1140	1231
General	410	432
Neurological	25	28
OB-GYN	208	213
Ophthalmology	155	171
Orthopedic Surgery	125	137
Otolaryngology	99	99
Plastic Surgery	15	21
Colon-Rectal	12	13
Thoracic	10	17
Urology	81	100
Other Specialties	784	850
Anesthesiology	173	199
Child Psychiatry	5	9
Forensic Pathology	0	1
Neurology	18	18
Occupational Medicine	43	41
Psychiatry	149	163
Pathology	120	120
Physical Medicine & Rehabilitation	2	6
General Preventive Medicine	6	5
Public Health	10	9
Radiology	156	182
Unrecognized	7	9
Unspecified	95	88

Another figure which might be of interest to the House is that in 1964, 90.4% of all physicians in Indiana were members of ISMA. Of the physicians rendering patient care for that year, 99.5% were members of the association. In 1965, 89% of the total physicians were members and 98.4% of the physicians rendering patient care were members. In 1966, 89.8% of the total physicians were members and of the physicians rendering patient care, 98.6% were members. For the year 1967, of the total physicians 89.1% were members and of the physicians rendering patient care 97.8% were members.

Another tabulation which might be of interest to you is the change in physician population by our medical districts. The columns below indicate the membership by medical districts for the year 1964 as compared to the membership for 1968. The third column indicates the number of physician members at the end of June 30, 1969. It is of concern that in 1964 we had 4,364 members and at the end of 1968, 4,440 for a net gain during that period of 76 and an average of 19 new physicians per year.

District	1964	1968	6 Mo. 1969
1	286	273	273
2	150	165	169
3	157	165	171
4	137	136	140
5	171	163	164
6	185	179	176
7	1137	1144	1134
8	249	256	253
9	254	264	261
10	463	512	509
11	246	237	241
12	416	430	442
13	513	516	507

It might be interesting also to note

that Indiana physicians who are members of the AMA increased from 4,256 at the end of 1964 to 4,286 by the end of 1968 and at the end of the first six months of 1969, AMA membership stood at 4,290.

Retention of physicians is a problem in other states. One of the Midwestern states, at their annual meeting, adopted two resolutions concerning the retention of physicians in their state. One resolution adopted called upon their medical school to refuse to accept as a student one who would not agree to serve a specified number of years in medical practice within that state.

The other resolution was that tuition charges be cancelled on a year to year basis for physicians who remained in practice in their state.

Another resolution in the same state called upon the association to finance an active program designed to sell the students' wives on the pleasures of life in the smaller towns of their state.

For your consideration, your secretary has informally discussed the following for the past year and a half but there are some matters of the future which should now have your attention and have your attention in the next months so that you and your staff will not be caught short on determination of policy.

I think you all recognize that there is going to be confronting you and confronting the public a tremendous growth in the numbers of paramedical personnel and there is going to be a growth in the number of those who hold themselves as a separate discipline akin to law, akin to medicine, but a separate discipline not within the borders of either. I feel it necessary to say to you that I think the matter of privileged communication, traditionally that of the medical profession, the lawyer and the clergy, should be reviewed in depth as to the extent it should be extended to the other fields coming into being.

And as we consider that matter, I think we should also consider the standards of malpractice that may be applied to the technicians and to the members of "other disciplines." You are seeing the limited licensee and the certified technician entering the hospital corridor. It is probably not a real problem as yet. But who knows? What patient is able to identify a person within the hospital staff and his responsibility and his liability?

And as you think of that, think of the problem attendant upon the keeping of notes. This has been your problem primarily with reference to nurses' notes. But as the psychologist enters the hospital (and he will, one of these days), and as a technician enters who is not strictly within the field of remedial medicine, are their notes to be put on the patient's record? And are those notes to have some relationship, at least in the matter of liability?

Also, you have certainly read in your various journals that the assistant doctor is about to come upon the scene. What is his liability? What is his privilege? What is his responsibility to you, the medical profession?

These, I think, are some of the challenges to you as physicians. I do suggest that we begin giving earnest consideration to some of the coming events which are on the horizon.

I want to thank the officers for their assistance and guidance, to thank every physician who served faithfully this year and further express my appreciation to the staff who also gave unstintingly of time, thought and industry.

JAMES A. WAGGENER,
Executive Secretary

The Treasurer

The 1969 fiscal year ended on September 30th and while we are meeting in convention the auditors are busy auditing our association records for the past year. I am sorry it is impossible to give you the audit figures for this year at this time but I am incorporating, as a part of this report, the annual audit for the fiscal year ending September 30, 1968. I can, however, give you a statement of the cash and investments and totals of all funds of the association for the first nine months of the year ending July 31, 1969.

SUMMARY OF ALL FUNDS

	Cash	*Investments*	*Total*
General Fund	$2,833.04	$326,215.51	$329,048.55
Journal Fund	14.43	—	14.43
Medical Defense Fund	5,264.46	25,000.00	30,264.46
Building Fund	6,464.93	—	6,464.93
Woman's Auxiliary Donation	—	4,054.96	4,054.96
Student Loan Fund (Old)	1,410.59	12,911.92	14,322.51
Dues Account	13,365.29	—	13,365.29
Kitchen Fund	—	5,609.71	5,609.71
Total all funds	$29,352.74	$373,792.10	$403,144.84

Comparing this with the same period of 1968, we had a total cash on hand of all funds of $53,071.43 as against $29,352.74 at the end of July 31, 1969 for a loss of $23,718.69. This change is brought about by the fact that we are attempting to keep as much of our cash in short term investments to earn as much as possible during the time when the funds are not needed for use. Our investment account as of July 31, 1968 amounted to $306,373.35 as against $373,792.10 at the end of July 31, 1969 for an increase in investments of $67,413.75. The total cash and investments of all funds as of July 31, 1968 amounted to $359,449.78. The comparable figure for July 31, 1969 is $403,144.84, showing an increase of $43,695.06.

The treasurer has consulted with the Executive Committee and the Board of Trustees who have reviewed the cash and investment portfolio of the association at each of their meetings. The treasurer has followed the advice of these bodies by investing all available cash in short term bills or savings accounts in order to accumulate as much interest as possible where funds were not required for current purposes.

LESTER H HOYT, M.D.
Treasurer

INDIANA STATE MEDICAL ASSOCIATION

Financial statements for the year
ended September 30, 1968
with
supplementary data

Board of Trustees,
Indiana State Medical Association,
Indianapolis, Indiana.

We have examined the statement of financial condition of the Indiana State Medical Association as of September 30, 1968, and the related statements of income and expense of the general fund and changes in fund balances for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying statements present fairly the financial position of the Indiana State Medical Association at September 30, 1968, and the results of its general fund operations and changes in fund balances for the year then ended in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

The accompanying supplementary information has been subjected to the tests and other auditing procedures applied in the examination of the financial statements mentioned above and, in our opinion, is fairly stated in all material respects in relation to the financial statements taken as a whole.

Geo. S. Olive & Co.
Certified Public Accountants

Indianapolis, Indiana

October 29, 1968

Exhibit A

INDIANA STATE MEDICAL ASSOCIATION

Statement of General Fund Income and Expense

	Year Ended September 30		
	1968 Budget	1968 Actual	1967 Actual
INCOME—notes 1 and 2:			
Dues	$309,622	$314,962.50	$312,701.25
Less: Dues allocated as follows:			
Building fund	38,850	39,120.00	38,790.00
American Medical Education fund	19,425	19,500.00	19,395.00
The Journal	31,960	32,176.00	31,944.00
Medical Defense fund	4,856	4,892.50	4,848.75
	95,091	95,688.50	94,977.75
Dues available for general fund operations	214,531	219,274.00	217,723.50
Other income:			
Interest income on investments	8,000	11,000.44	9,070.97
Received from American Medical Association	2,500	2,737.08	2,572.63
The Journal—net income—schedule A-1	277	5,263.79	4,306.24
Miscellaneous	27,000	1,654.79	1,480.20
	252,308	239,930.10	235,153.54
EXPENSE:			
Committees and commissions—schedule A-2	14,450	11,675.98	22,997.24
Officers and Council—schedule A-2	33,250	36,522.63	31,691.63
Headquarters office—schedule A-3	166,719	155,167.21	153,045.95
Annual meeting expense (income)—schedule A-4	1,000	3,835.90	(195.46)
Membership expense	6,000	9,411.02	-----
Dues, subscriptions and donations	3,500	4,326.99	3,384.07
Employees' retirement expense	9,500	8,237.30	9,875.88
Loss on guaranteed student loans	-----	2,519.54	-----
	234,419	231,696.57	220,799.31
NET INCOME	$ 17,889	$ 8,233.53	$ 14,354.23
ALLOCATED AS FOLLOWS:			
General fund—exhibit C		$ 14,220.61	
Building fund—exhibit C		(5,987.08)	
		$ 8,233.53	

The accompanying notes are an integral part of this statement.

INDIANA STATE MEDICAL ASSOCIATION

Statement of Financial Condition at September 30, 1968

ASSETS

General Fund:		
Cash on deposit and on hand		$ 43,763.03
Certificates of deposit		150,000.00
U. S. Treasury bonds (market value $45,960)		55,102.22
Investment in mutual fund		25,078.90
Securities and cash in escrow account		3,000.00
Accounts receivable		8,004.68
Reimbursement due from U. S. Government for processing Champus claims		2,863.62
Prepaid expenses and miscellaneous assets		7,214.03
Office furniture and equipment—at cost	$ 67,767.07	
Less: Accumulated depreciation	33,341.27	
		34,425.80
		$329,452.28
Building Fund:		
Cash on deposit		4,823.10
Cash in savings account		4,054.96
U. S. Treasury bills—at cost plus earned discount		24,710.35
Prepaid expense		402.33

Meridian Street property:			
Land		69,187.60	
Office building	$299,354.38		
Less: Accumulated depreciation	38,634.06		
		260,720.32	
		329,907.92	
Rental properties—at cost (net of $4,776.28 of accumulated depreciation)		88,381.72	
Due from general fund		832.60	
			453,112.98
Student Loan Fund:			
Cash in savings account		14,177.08	
Certificates of deposit—note 3		20,810.00	
Notes receivable from students		5,012.92	
			40,000.00
Medical Defense Fund:			
Cash on deposit		2,750.04	
U. S. Treasury bonds plus accrued interest receivable		25,373.80	
Due from general fund		960.53	
			29,084.37
Champus Fund (formerly Medicare):			
Cash on deposit		8,888.10	
Reimbursement due from U. S. Government for advance payments made to doctors		65,611.90	
			74,500.00
			$926,149.63

The accompanying notes are an integral part of this statement.

Exhibit B

LIABILITIES AND FUND BALANCES

General Fund:			
Accounts payable		$ 10,759.11	
Accrued payroll and property taxes		11,201.91	
Allocation of dues payable to American Medical Education and Research Fund		19,500.00	
Advances from American Medical Association		10,319.19	
Unearned portion of 1968 dues		73,443.75	
Exhibitors' deposits for 1968 annual meeting		15,488.75	
Due to other funds:			
Building fund	$832.60		
Medical Defense fund	960.53		
		1,793.13	
Fund Balance—exhibit C		186,946.44	
			$329,452.28
Building Fund:			
Loans from members (non-interest bearing)		22,825.00	
Accrued property taxes		2,091.33	
Guarantee and damage deposits		425.00	
Fund balance—exhibit C		427,771.65	
			453,112.98
Student Loan Fund:			
Fund balance—exhibit C:			
Principal balance appropriated from general fund—note 3		40,000.00	
			40,000.00
Medical Defense Fund:			
Fund balance—exhibit C		29,084.37	
			29,084.37
Champus Fund:			
Fund balance (cash advanced by U. S. Government)—exhibit C		74,500.00	
			74,500.00
			$926,149.63

INDIANA STATE MEDICAL ASSOCIATION

Statement of Changes in Fund Balances,
Year Ended September 30, 1968

	General Fund	Building Fund	Student Loan Fund	Medical Defense Fund	Champus Fund
Balances, October 1, 1967	$177,203.88	$394,444.97	$40,000.00	$32,247.51	$75,000.00
Additions:					
Net income year ended September 30, 1968—exhibit A	14,220.61	(5,987.08)			
Dues allocated to restricted funds		39,120.00		4,892.50	
Other income credited directly to restricted funds		734.73		1,008.15	
	14,220.61	33,867.65		5,900.65	
Deductions:					
Prior years' adjustments charged directly to fund balance	4,478.05				
Expenses charged directly to restricted funds:					
Building fund:					
Rental property expense (net of rental income of $5,100)		540.97			
Medical Defense fund:					
Legal fees				3,925.00	
Malpractice defense fees				5,138.79	
Funds returned to U. S. Government					500.00
	4,478.05	540.97		9,063.79	500.00
Balances, September 30, 1968—exhibit B	$186,946.44	$427,771.65	$40,000.00	$29,084.37	$74,500.00

The accompanying notes are an integral part of this statement.

INDIANA STATE MEDICAL ASSOCIATION

Notes to Financial Statements at September 30, 1968

NOTE 1—GENERAL PURPOSE AND NATURE:

The Association was organized as the Indiana State Medical Society in 1849. The Articles of Incorporation were amended in 1926 to change the name to the Indiana State Medical Association.

The purposes for which the Association was formed were to extend medical knowledge; advance medical science; elevate standards of medical education; enlighten the public in regard to problems of medical care, public health, cure of disease; thereby prolonging and adding comforts to life.

The Association is exempt from the payment of federal income tax (except on unrelated business income) under the provisions of section 501 of the Internal Revenue Code as an organization formed and operated to promote the objectives outlined above.

NOTE 2—METHOD OF ACCOUNTING AND BASIS OF ASSETS:

The Association maintains its books and records on the accrual basis. Investments in securities, rental properties and various other assets reflected in the statement of financial condition are carried at cost if purchased or at market value at date of receipt if acquired by gift. Unless stated otherwise, the market value of investments approximates cost.

Depreciable assets are carried at cost and are depreciated on the straight-line method with such depreciation charged as a general fund operating expense.

The assets, liabilities and operations of *The Journal*, the Association's monthly publication, are reflected as a part of the general fund in the accompanying financial statements. The budget for the year ended September 30, 1968 has been adjusted to include the operations of *The Journal* and for various equipment expenditures which have been capitalized and are being depreciated as indicated above.

NOTE 3—STUDENT LOAN FUND PRINCIPAL:

The Student Loan fund is a separate irrevocable charitable trust established in October, 1955, for the purpose of making loans to medical students. The assets and equity of this trust are included in the accompanying financial statements in order to reflect the fiduciary responsibilities of the Indiana State Medical Association as trustee of the fund. This loan fund was created and funded through cash appropriations from the general fund totaling $40,000 over a five-year period beginning in May, 1956.

INDIANA STATE MEDICAL ASSOCIATION

Notes to Financial Statements at September 30, 1968

Under the terms of an agreement with The Indiana National Bank of Indianapolis, the bank is making loans to students enrolled and in satisfactory standing at the Indiana University Medi-

cal School at the rate of twelve and one-half dollars for each dollar placed in a capital reserve at the bank. As of September 30, 1968, the bank held $20,810 in this capital reserve (represented by certificates of deposit) thereby producing an available loan balance approximating $260,000, of which $15,800 had been loaned to medical students. The Association is contingently liable for these latter loans to the extent of the collateral only.

The Executive Committee, in conjunction with the Student Loan Committee, is to review the student loan situation annually for the purpose of authorizing further general fund appropriations to the loan fund as additional funds are needed to guarantee loans under the agreement with The Indiana National Bank.

SUPPLEMENTARY DATA

Schedule A-1

INDIANA STATE MEDICAL ASSOCIATION

The Journal Statement of Operations

	Year Ended September 30		
	1968 Budget	1968 Actual	1967 Actual
INCOME:			
Subscriptions—members	$31,960	$32,176.00	$32,600.00
Subscriptions—non-members	1,000	1,902.00	1,520.00
Advertising	50,000	55,905.95	50,926.27
Other	3,000	5,827.41	3,606.05
	85,960	95,811.36	88,652.32
EXPENSE:			
Salaries, commissions and outside help	20,000	19,987.89	19,267.82
Printing and reprints	49,000	54,311.03	49,746.80
Engraving, art work and photographs	5,000	5,361.32	5,088.85
Office supplies and postage	700	584.23	545.98
Travel and meeting expense	1,800	1,710.11	1,684.19
Bulk mailing	1,500	1,583.28	1,455.61
Other publishing expense	600	772.40	579.30
Payroll taxes	500	477.56	486.26
Rent and utilities	3,450	3,408.00	3,408.00
Telephone and telegraph	450	359.11	367.64
Insurance and retirement	750	694.25	690.75
Equipment replacement	800	-----	-----
Cash discounts allowed and miscellaneous	1,133	1,298.39	1,015.88
	85,683	90,547.57	84,346.08
NET INCOME—exhibit A	$ 277	$ 5,263.79	$ 4,306.24

Schedule A-2

INDIANA STATE MEDICAL ASSOCIATION

Analysis of Operating Expense—
Committees and Commissions—Officers and Council

	Year Ended September 30		
	1968 Budget	1968 Actual	1967 Actual
COMMITTEES AND COMMISSIONS:			
Standing committees:			
Grievance	$ 250	$ 223.11	$ 161.00
Student Loan	50	32.64	11.40
Future Planning	300	101.74	70.42
Commissions:			
Constitution	300	495.97	107.00
Inter-Professional Relations	300	70.10	236.00
Legislation	300	494.04	2,341.42
Public Health	400	285.74	449.40
Public Information	600	198.48	-----
Special Activities	300	341.41	298.55
Voluntary Health Agencies	400	345.96	303.44
Medical Economics and Insurance	300	457.21	609.72
Medical Education and Licensure	300	410.53	338.71
Governmental Medical Services	300	322.54	126.99
Aged and Aging	350	615.90	255.23
Education	7,500	6,108.66	13,001.77
Special programs and miscellaneous	2,500	1,171.95	4,686.19
Totals—exhibit A	$14,450	$11,675.98	$22,997.24
OFFICERS AND COUNCIL:			
President	$ 6,500	$ 5,853.92	$ 4,205.70
President-elect	750	1,045.20	624.80
AMA meetings	15,000	18,322.79	14,320.44
Treasurer's office—auditing	2,500	2,435.00	2,475.00
Council chairman and Council meetings	7,500	7,944.74	9,162.08
Executive Committee meetings	1,000	920.98	903.61
Totals—exhibit A	$33,250	$36,522.63	$31,691.63

Schedule A-3

INDIANA STATE MEDICAL ASSOCIATION

Analysis of Operating Expense—Headquarters Office

	Year Ended September 30		
	1968 Budget	1968 Actual	1967 Actual
Salaries	$105,219	$ 85,908.83	$ 74,421.11
Telephone and telegraph	5,500	6,165.85	5,196.19
Postage	5,500	3,988.25	4,361.13
Printing and office supplies	6,000	4,568.88	5,660.97
Travel, entertainment and field expense	14,000	9,880.19	12,484.68
Building operations and utilities	10,000	10,560.73	8,674.28
Insurance	7,000	6,374.22	6,828.91
Extra help	500	98.00	72.50
Payroll taxes	3,000	2,898.97	2,610.48
Property taxes	7,500	7,311.84	7,244.64
Equipment maintenance	1,500	1,924.81	1,403.36
Depreciation	----	10,394.77	13,593.44
Champus expense in excess of reimbursement	----	4,149.36	9,872.68
Miscellaneous	1,000	942.51	621.58
Totals—exhibit A	$166,719	$155,167.21	$153.045.95
		10,394.77	
		144,772.44	

Schedule A-4

INDIANA STATE MEDICAL ASSOCIATION

Analysis of Operating Expense—Annual Meeting

	Year Ended September 30	
	1968	1967
Convention planning	$ 1,640.15	$ 248.79
Speakers' travel and expense	2,500.00	923.02
Technical exhibits, circulars, etc.	1,121.40	678.35
Scientific program and exhibits	645.00	678.35
Programs, handbooks and printing	2,889.94	2,659.56
Badges	295.71	185.40
Meetings—Council and House of Delegates	898.89	192.00
Telephone service	237.35	33.00
Office personnel expenses	458.55	623.66
Plaque awards	218.88	344.62
Prizes—annual meeting	151.50	123.95
50-year club	79.57	158.84
Photography	365.00	358.50
Banquet, luncheon and party	7,278.66	840.00
Miscellaneous	1,315.30	3,869.00
	20,095.90	11,917.04
Less: Income from exhibitors' booths	16,260.00	12,112.50
Excess of expense (income)—exhibit A	$ 3,835.90	$(195.46)

Chairman of the Board

For the Board, the chairman wishes to express his thanks to the president, president-elect, to the chairman and the other members of the Executive Committee for their splendid spirit of cooperation that has prevailed during the past year. The headquarters staff has been most helpful on every occasion when I requested their aid; Mr. Jim Waggener especially left no stone unturned to aid the Board in its work.

Personally the chairman wants to thank the individual members of the Board for allowing him to serve as their chairman during the past year. This has been a most gratifying experience—one which makes a person feel quite humble when he is confronted with the individualism of the 12 other trustees.

The chairman specifically wants to bring to the attention of the House of Delegates the very high rate of attendance and participation by the various trustees. Attendance this year has been higher than any other year during my tenure on the Board. In addition the alternate trustees have also shown a higher attendance rate than ever before. There were very few times when each trustee district was not represented.

By the time of the annual meeting, the Board will have held seven meetings. Two of these were especially noteworthy because of their content. In January, the Board held a joint meeting with selected members of the faculty of the I.U. School of Medicine who were chosen by Dean Glenn Irwin. Two areas of discussion were presented by members of the faculty: namely, Medical School Admissions Standards and Procedures; secondly, the new medical school core curriculum. There was a free exchange of ideas between the two groups and the Board felt that this was a very worthwhile project.

In March the Board met in Chicago for a four-day session. The first two days were devoted to regular form business and also to participation in an intensive public-speaking course conducted by the Public Information Division at AMA headquarters.

During the last two days the Board attended the AMA Congress on Socioeconomics of Medicine. The main topic at this year's congress was the various means and methods of health care delivery. The experience was very meaningful to the Board.

The headquarters staff completed and distributed to the Board members a pamphlet index on the quotation "Authority and Responsibilities of the Duties of the Board of Trustees of ISMA." This should prove quite helpful to the Board members.

The Board continued to function to a greater extent through the committee system. This allows the Board to be much better informed in that individual members can become more knowledgeable in specific areas; the various committees can bring specific recommendations to the Board with all the investigating work done beforehand. This also proves to be a time-saver to the Board as it becomes increasingly busier.

The chairman hopes that the committee system can become more broadly developed as time goes by. However, the Board must be careful that it does not usurp unto itself or any of its committees such executive duties that are properly the function of the president and his headquarters staff.

Dr. Reid's Committee on Medical Use of Computers and Dr. McIntosh's Committee on Governmental Medical Programs are especially to be commended on their fine work. Dr. Clark's Committee on Orientation of New Members presented a very worthwhile program at Fort Wayne in 1968, and this activity should be continued.

The Board considered several items on which they will undoubtedly submit resolutions to the House of Delegates. The Board feels that in order to meet the increasing cost of maintaining the headquarters due to inflation and in order to consider several new programs, an increase in dues will probably be necessary.

The House at the 1968 convention mandated the Board to submit a recommendation on revision of trustee districts. This was in reponse to Resolution 68-10. Similar resolutions were introduced in 1958 and 1966. An ad hoc committee of the Board is considering this matter and the Board will have a report to the House on its findings.

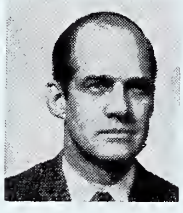
During the past year representatives of the Indiana University Chapter of the Student American Medical Association have been invited to the Board meetings and to various commission meetings. Attendance and participation have been good. At a recent Board meeting, the president of I.U.-SAMA requested that we consider giving their chapter representation in the House of Delegates. The Board feels that this should be considered by the House of Delegates.

The Board approves, subject to confirmation by the House, that ISMA hold a Health Week in the spring of 1970 to which high school students from throughout the state be invited to Indianapolis to hear capable speakers on various subjects relative to health and of interest to today's youth. This is a program which the Board feels is very worthwhile but which would undoubtedly require more financial support than our present income will provide.

The chairman attended eight of the 11 district meetings that were held this spring. At each of these the district trustee and the district officer went to considerable effort and in some instances considerable expense to put on a good program; however, in nearly every case, attendance was poor or worse. Nearly every district attendance was certainly less than ten percent of the membership. This is extremely distressing when one considers that important decisions are being made at these meetings in which so few of the members participate. The district trustees and the district Blue Shield board members are elected at the district level. Certainly no member can criticize the decisions of his representative if he will not take part in the democratic process by which these representatives are elected. The House may want to consider methods whereby this situation can be corrected.

DONALD R. TAYLOR, M.D.,
Chairman

First Trustee District



GILBERT M. WILHEMUS, M.D.,
Trustee

The annual meeting of the First District Medical Society was held May 22, 1969, at the Evansville Country Club. The meeting was well attended by members and their wives.

Mead Johnson & Company was host for our social hour preceding the dinner. Mr. Miller, a national distillery representative from New York City, talked on the subject of wines, the history and their enjoyment. Dr. George W. Willison, Blue Shield director, reported to the group; and Dr. Gilbert M. Wilhelmus reported the past and present business activities of the Indiana State Medical Association. After the meeting the following officers were elected: James Hobgood, M.D., president; Fred Smith, M.D., vice-president; and Raymond Burnikel, M.D., secretary-treasurer.

The Vanderburgh County General Practice Group was host to the Indiana Academy of General Practice state convention this year, and the large group of physicians who attended the convention were impressed with the state meeting and also

the new civic center where the convention was held.

The Vanderburgh County Medical Society has worked very diligently this year, particularly in the mental health field.

GILBERT M. WILHEMUS, M.D., *Trustee*

Second Trustee District



JOE DUKES, M.D.,
Trustee

Your trustee has been active this past year attending all scheduled meetings of the Board of Trustees, in addition to several other meetings of related interest: the socioeconomic program in Chicago last March, the conference of County Medical Society Officers, along with Blue Shield activity especially concerned with comprehensive health.

The second district meeting was held this year at the Country Club in Sullivan on May 22nd. The scientific program was put on by Indiana University and the Mental Health Association.

The program was: "Psychiatry In Everyday Practice," moderated by Dr. Betty J. Dukes. Lecturers: William Vance, M.D.; Hanus J. Grosz, M.D. and James J. Wright, M.D. Subjects were: "Depression," "Alcoholism" and "The Suicidal Patient."

At the business meeting Dr. J. S. Brown of Carlisle was elected secretary for the district for the 47th time and Dr. Joe Dukes of Dugger was re-elected trustee for his second term.

Dr. Vance Chattin on behalf of the Knox County Medical Society invited the district meeting to be held in Vincenes next year.

JOE DUKES, M.D., *Trustee*

Third Trustee District



DONALD M. KERR, M.D.,
Trustee

The Third District meeting was held at the Robert E. Lee Motel in New Albany on the first Wednesday in April. The meeting was under the direction of Dr. Daniel Cannon, Third District president, who was re-elected to district presidency. Special guests were Dr. Donald Taylor, chairman of the Board of Trustees and Dr. Malcolm Scamahorn, assistant treasurer, ISMA.

The program, which was well attended and of obvious interest, dealt with problems of human sexuality and was additionally noteworthy for the large number who stayed until the final evening sessions were terminated.

Once again in the district was seen the tragedy of good physicians falling into the trap of narcotics addiction with resultant loss to themselves, their families, their community and their profession. Your trustee urges all physicians to be ever mindful of the ease with which those who deal daily with such drugs seem to develop a contemptuous familiarity, and of the ensuing tragedy.

DONALD M. KERR, M.D., *Trustee*

Fourth Trustee District



ROBERT M. REID, M.D.,
Trustee

The district meeting of the fourth district was held at Batesville, Indiana, on May 14. Attendance was fairly good. The program, in addition to golfing and social activities, included several physicians who presented scientific papers. The speakers were: Leon Goldman, M.D., Professor of Dermatology, University of Cincinnati; Bruce G. McMillan, M.D., Shrine Professor of Surgery and Chief of Staff of the Burn Unit, University of Cincinnati; and John I. Nurnberger, M.D., Chairman of the Department of Psychiatry, Indiana University School of Medicine.

The delegates' meeting was attended at a level barely above quorum. Those present participated in a discussion of district matters; the present status of comprehensive health planning in our district; possible alternatives available in the attempt to meet the many problems in the delivery of health care with particular reference to the relatively rural area; the continuing concern regarding diminishing interest of district activities and the possible applications of a $10 assessment voted for district members at the 1968 meeting. The unusually high number of follow-up contacts pertaining to this discussion has been encouraging.

As a representative of so-called organized medicine, I continue to be concerned about the minimal degree to which the membership looks to its organization for leadership. It seems incredible that so many dedicated and capable individuals have given so generously of time and talent with the results that are apparent to nearly all of us today. It is obvious either we are not addressing ourselves to the vital interests of the membership or that we have not earned the confidence that we can deal effectively with these interests.

I believe profoundly that the great majority of physicians are genuinely and primarily concerned with the effective delivery of health care to their patients. I believe that this should be the prime concern of our organization. I hope and am encouraged to believe that imaginative and promising departures, with a strictly traditional organizational effort, will offer new and rewarding interests within the next several months and years. I would hope that we will see a vigorous and enlightened reaction to our many challenges formulated by and executed by physicians, individually and collectively. If we do not, we will forfeit the very justification of our existence.

ROBERT M. REID, M.D., *Trustee*

Fifth Trustee District



WILBERT McINTOSH, M.D.,
Trustee

This district meeting was held at the Terre Haute Country Club April 30, 1969. The afternoon session of the meeting was called to order at 4:00 p.m. by Dr. Herzberg, Clinton, Indiana.

Reports were made from various committees. Mr. Dixon reported on the progress of Blue Shield; Mr. Amick, field man, made a brief report.

A discussion was held and a committee appointed to investigate methods of invigorating and increasing the interest and attendance of the local districts. The committee is to contact other districts in Indiana to facilitate this. The meeting was adjourned for dinner.

Dr. Andrew Offutt was the after-dinner speaker; his subject was "Comprehensive Health Planning." The visiting dignitaries at the dinner meeting were Dr. Malcolm Scamahorn and Dr. Donald Taylor, both of whom are candidates for the next presidency of the Indiana State Medical Association.

Election of officers was held. The new

officers: Dr. William Tipton, Greencastle, president; Dr. Cleon M. Schauwecker, Greencastle, secretary-treasurer.

The next annual meeting will be held at Greencastle, Indiana at a date to be determined later.

WILBERT McINTOSH, M.D.,
Trustee

Sixth Trustee District



STEPHEN D. SMITH, M.D.,
Trustee

This year's activities in the Sixth District Medical Society area, which includes the medical societies in the area known as "God's Country" along Little Blue River and East, i.e., Hancock, Rush, Shelby, Fayette, Union, Wayne and Henry Counties —was culminated by a spirited meeting at Richmond the 1st day of May, 1969. This meeting started with a tour and a lecture of the Reid Memorial Intensive Cardiac Care Unit and also of the Acutc and Chronic Respiratory and Inhalation Therapy Department. These discussions were led by Drs. Linn and Ramsdell, respectively.

Following the afternoon of intellectual stimulation, there was a business meeting for the Sixth District with Dr. Stephen D. Smith, president, as the presiding officer. A short discussion of problems concerning malpractice legation was presented by Shelby County following which it was moved and seconded that this be further investigated. Following this, elections were held for the coming year which were: Dr. Perry Seal, Brookville, president; Dr. David Wynegar, Richmond, vice-president; Dr. Mark Smith, New Castle, secretary and treasurer and Dr. Frank Green, alternate trustee. The place of the 1970 meeting will be Westwood Country Club, New Castle, Indiana. We were honored by guests representing the state medical society in the persons of Dr. Donald Taylor, Muncie, chairman of the Board of Trustees and Dr. Malcolm Scamahorn, Pittsboro, assistant treasurer. Also honoring us with his presence was Mr. Herbert Dixon of Blue Shield.

This was followed by dinner for the doctors and their wives at which time prizes were awarded to the golfers.

After dinner Dr. Felix Manfredi of the Veteran's Administration Hospital, Indianapolis, gave a discussion, incorporating visual aids, as to current therapy and approach to the treatment of respiratory failure.

There have been many persons contact me suggesting the possibility of changing the district medical meeting so that there will be better representation of all of the counties involved. Some thought has been generated around the idea of having a meeting of trustee, alternate trustee, and president and secretary of each component county medical society twice a year. This foregoing should be studied in depth for the entire state.

STEPHEN D. SMITH, M.D.,
Trustee

Seventh Trustee District



JAMES A. GOSMAN, M.D.,
Trustee

The annual meeting of the Seventh District Medical Society was held at 7:00 p.m., Wednesday, April 30, 1969, at Marion County General Hospital, in Indianapolis, with the president, Dr. John O. Butler, presiding.

Dr. Butler introduced Dr. Lester D. Bibler, former trustee of the American Medical Association, and Mrs. Bibler; Dr. Hugh K. Thatcher, president of the Marion County Medical Society; Dr. Glen V. Ryan, chairman of the Blue Shield Board of Directors; Mr. Richard C. Kilborn, president of Blue Shield, and Dr. Harold C. Ochsner, former AMA delegate.

Dr. Bibler, with several seconds, moved that the minutes of the previous meeting not be read. The motion was carried.

In the absence of Dr. Donald E. Stephens, secretary-treasurer, Dr. Butler presented the treasurer's report showing a bank balance of $901.75 as of April 30, 1969.

Dr. Butler then called for nominations for president-elect of the society, to serve in 1970-71. Dr. Ryan nominated Dr. Ellery T. Drake, of Martinsville. Dr. Bibler moved that the nominations be closed and that Dr. Drake be declared elected unanimously. The motion was carried.

Dr. Butler asked for nominations for secretary-treasurer. Dr. Edwin S. McClain nominated Dr. Stephens to succeed himself. Dr. Ted L. Grisell then moved that the nominations be closed and that Dr. Stephens be declared elected unanimously. The motion was carried.

Dr. Butler called for nominations for alternate trustee of the Indiana State Medical Association. Dr. Thatcher nominated Dr. Butler to succeed himself and Dr. Robert W. Mouser moved that the nominations be closed and that Dr. Butler be declared elected unanimously. The motion was carried.

Dr. Butler called for nominations for director of Blue Shield. Dr. Thatcher nominated Dr. Ryan to succeed himself. Dr. Mouser moved that the nominations be closed and that Dr. Ryan be declared elected unanimously. The motion was properly seconded and carried.

Dr. Joseph Kerlin, of Danville, president of the Hendricks County Medical Society, presented the following resolution from that organization and his motion, properly seconded, that it be adopted, was carried:

"WHEREAS, Malcolm O. Scamahorn, M.D., of Pittsboro, is an announced candidate for president-elect of the Indiana State Medical Association proposed by the Hendricks County Medical Society, which is vigorously supporting him, and,

"WHEREAS, Dr. Scamahorn has served the local medical society, his profession, his community, the Indiana State Medical Association, as well as the Seventh District Medical Society, long and well,

"THEREFORE, BE IT RESOLVED, that the Seventh District Medical Society endorse the candidacy of Malcolm O. Scamahorn, M.D., of Pittsboro, for president-elect (1969) of the Indiana State Medical Association."

Dr. Butler called for new business and Dr. Thatcher moved that the stipend of the executive secretary be increased to $100 annually. The motion was seconded by several and carried.

The president expressed the appreciation of the society to Dr. Arvine G. Popplewell, superintendent of Marion County General Hospital, for having members and their ladies as guests of the institution for dinner and the meeting, and turned the meeting over to Dr. Scamahorn, incoming president.

Dr. Scamahorn presented Dr. McClain, who introduced Mr. Brian L. Bex, of Bloomington, guest speaker.

Following the address by Mr. Bex, the meeting was adjourned.

JAMES A. GOSMAN, M.D.,
Trustee

Eighth Trustee District



DONALD R. TAYLOR, M.D.,
Trustee

The Delaware-Blackford County Medical Society hosted the annual meeting of

the Eighth District Society at Delaware Country Club in Muncie on June 11, 1969. The meeting was chaired by Dr. Francis E. Stout, president, with the assistance of Dr. Richard Philbert, secretary-treasurer.

The activities and problems of the Indiana State Medical Association were discussed by the district trustee. He especially noted that there has been a marked decrease in AMA membership among the physicians of the district. This was explained by dissatisfaction with AMA policies and activities during the past year by the conservative membership of this area.

Mr. Herbert Dixon talked briefly on Blue Shield problems and programs during the past year and Mr. Jim Waggener reported on activities from the ISMA office.

Dr. Richard Ingram of Montpelier was elected as trustee to succeed Dr. Donald R. Taylor who has completed two terms as counselor and trustee as of October, 1969.

Following a social hour, dinner was served to about 65 members and guests. Dr. Jack Hickman, assistant dean of student affairs at Indiana University Medical School furnished a very interesting program. He was aided by four I.U. medical students who described the activities of the student council, of the Student American Medical Association, and of the Student Community Clinic which they staff in Indianapolis.

The 1970 meeting will be conducted by the Randolph County Medical Society in June, 1970. Dr. David J. Landon was elected president; Dr. Carol R. Chambers, secretary-treasurer and Dr. Richard Ingram, trustee.

DONALD R. TAYLOR, M.D.,
Trustee

Ninth Trustee District



PETER R. PETRICH, M.D.,
Trustee

The annual meeting of the Ninth District Medical Society was held this year at Lafayette, Indiana, at the Lafayette Country Club, Tippecanoe county being the host society.

A very fine day was enjoyed by many of the physicians of the ninth district and the featured speaker of the evening was Representative Richard Roudebush.

During the past year I trust that the officers of the society have shared with their membership reports which have been forthcoming following the meetings of the Board of Trustees. It is urgent that all of us take an active part in the business of organized medicine and in the business of Indiana State Medical. The business of our society is your business and your business is our business. We will try our best to do everything that we can for you in the way of aids to your office, etc. We hope that we may enjoy your help from time to time when called upon. If you are contacted to serve on a commission or committee and it is at all possible for you to do so, please signify consent and cooperate by appearing at meetings and doing the part that you are given to do. It has been a pleasure to be with many of you during the past year, and I hope to see you all again through the next year.

PETER R. PETRICH, M.D.,
Trustee

Tenth Trustee District



VINCENT J. SANTARE, M.D.,
Trustee

The Tenth District Medical Society had two successful meetings during the current year. The first meeting was held September 25, 1968 at the Red Lantern Inn, Beverly Shores, Indiana. Raymond J. Doherty, M.D., secretary of the tenth district society, presided at a dinner attended by 120 doctors and their wives. The minutes of the May meeting were approved as published in the *Bulletin of the Lake County Medical Society*.

Dr. Doherty introduced John Reed, M.D., president of the Porter County Medical Society; Peter Petrich, M.D., Councilor of the Ninth Medical District of the Indiana State Medical Association; Mr. Herbert P. Dixon, vice-president and physicians relations director of Indiana Blue Shield; Mr. James A. Waggener, executive secretary of the Indiana State Medical Association; Mr. Howard Grindstaff, field secretary of the Indiana State Medical Association, and Lowell H. Steen, M.D., chairman of the Council of the Indiana State Medical Association.

Mrs. Lambro Dimitroff, president, woman's auxiliary, Lake County Medical Society, conducted a raffle of a money hat to raise funds to support the auxiliary programs. The raffle was won by Mr. Dixon who donated the money to a child sponsored by the Christian Children's Fund, living in Brazil. This money was given as a Christmas present to the child.

Dr. Doherty conducted an election of officers with the following individuals elected: Councilor, tenth district of the Indiana State Medical Association to succeed Lowell H. Steen, M.D., at the expiration of his term December 31, 1968—V. J. Santare, M.D., of Munster; alternate councilor—Tom Disney, M.D., of Gary, to complete the unexpired term of Herman Wing, M.D., who resigned because he had moved to Chicago; president of the Tenth District Medical Society—R. J. Doherty, M.D., of Merrillville; secretary of the Tenth District Medical Society, Lambro Dimitroff, M.D., of Calumet City, Illinois.

V. J. Santare, M.D., chairman of the Lake County Medical Society Committee on Governmental Programs, conducted a panel discussion on Comprehensive Health Planning. Other participants in this panel were Norman J. Wilson, M.D., president of the Inter-Agency Health Council; Mr. James A. Waggener, executive secretary of the Indiana State Medical Association, and Dr. Tom Sherrard, Director of Urban Development Institute of Purdue University.

On April 9, 1969, the spring meeting of the tenth district was again held at the Red Lantern Inn, Beverly Shores, Indiana. During dinner, Dr. Doherty, who presided at the meeting, presented Donald R. Taylor, M.D., chairman of the Board of Trustees of the Indiana State Medical Association: Malcolm O. Scamahorn, M.D., assistant treasurer of the Indiana State Medical Association; Mr. Howard Grindstaff, field secretary of the Indiana State Medical Association; Mr. Herbert P. Dixon, vice-president of Blue Shield of Indiana; V. J. Santare, M.D., tenth district trustee; and Lowell H. Steen, M.D., president-elect of Indiana State Medical Association. Thomas Tyrell, M.D., of Calumet City, Illinois was elected alternate trustee to the Indiana State Medical Association Board of Trustees. His term is to begin in October, 1969 at the organizational meeting of the Board of Trustees. An election was also held for the tenth district board member of the Blue Shield Board of Directors. Seymour W. Shapiro, M.D., of Merrillville was elected.

President-Elect of the Indiana State Medical Association, Lowell H. Steen, M.D., made a report on state association affairs, with particular emphasis on programs in continuing medical education, Medicaid, and the Conference of County Society Officers that was scheduled for April 12th and 13th, 1969 in Indianapolis

The tenth district trustee of Indiana State Medical Association made a report on the recent activities of the State Association Board, with emphasis on Comprehensive Health Planning.

Ross L. Egger, M.D., the principal speaker for the meeting, who is regional advisor of the American Academy of General Practitioners Commission on Education, urged more active participation and discussed the reasons for the standards for certification by the new American Board of General Practice. He outlined the techniques of the examination to be given, which will certify general practitioners by this new board, and detailed at great length the long period of time that board certification for generalists had been under study.

In accordance with the usual, customary, and reasonable activities of the tenth district, we have had another active and productive year. We have taken pride in pioneering in the field of utilization review, and in continuing medical education on a district-wide basis. We continued to function with minority participation and hope that as time passes we will see further involvement by our sister counties in the district who progressively have become more viable and active in the past two years. We believe that the key to an active and functional state association is the vigorous participation of each district society in the affairs of ISMA, and in order to obtain participation on a wide and active basis, we urge and have worked toward the broadening of the base of activity by involving more individuals in committee function and by fragmentation of many of the large committees into more functional units.

VINCENT J. SANTARE, M.D.,
Trustee

Eleventh Trustee District



LOWELL J. HILLIS, M.D.,
Trustee

The meeting of the Eleventh Trustee District in Delphi, Cass County, Indiana, was on September 18, 1968. The activities in this area have been largely confined to local county aetivities.

At the meeting in Delphi, Dr. John Jarrett of Grant County was elected the president, and Dr. Fred Poehler of Wabash County was elected secretary-treasurer. Dr. James Harshman was re-elected alternate to the Board of Trustees of the Indiana State Medical Association.

The next meeting of this district will be held in Marion, Indiana, September 17, 1969. The meeting will be held at Emily's Restaurant, and the program is being arranged by Dr. Eugene Rifner.

The county activities in this district have been mainly those associated with comprehensive health planning. Howard County and Grant County have made great strides in comprehensive health planning under the leadership of Drs. James Harshman and Lester Renbarger. Cass County is in the final stages of completing its comprehensive health plan. and Miami and Wabash Counties are working in this field.

Notice will be made of the activities of the County Board of Health in Carroll County, under the direction of Dr. T. Neal Petry and Dr. C. L. Wise, in cooperation with the other members of the Carroll County Medical Society, this organization has become a model in the functioning of a county board of health in cooperation with the county medical society and their work has progressed nicely.

The Miami County Society and the Wabash County Society have been fortunate in the progress they have been able to make in their clinical laboratory and radiological departments. These departments now enjoy some of the most advanced diagnostic procedures in the state.

Very little work has been done in the area of emergency medical services. The formation of the Emergency Medical Services Commission has resulted in awaiting the results of the "trailblazing," and other procedures that are being done in Allen County. When these procedures have been tested, they will undoubtedly be carried on in these contiguous counties.

Your trustee has attended several fine meetings, especially in Wabash County and Miami County. Another fine meeting is to be held in Wabash County before our next district meeting.

Most of the activities in this district may be described as "business as usual."

LOWELL J. HILLIS, M.D.,
Trustee

Twelfth Trustee District



WILLIAM R. CLARK, SR., M.D.,
Trustee

Last year I reported that the Twelfth District had started undergoing reorganization. The purpose of the reorganization was to improve the communication between the trustee, the county officers and each individual member of the Twelfth District. I had hoped that I could create a better understanding of the problems that confront organized medicine today. I hoped that more interest could be stimulated in getting more M.D.'s (both young and old) in the future destiny of organized medicine. I hoped and asked for the cooperation of the members and the officers so that I could better represent them at the state level; thereby making it possible to coordinate the activities of the district with the Indiana State Medical Association in inproving our own image and better patient care.

We have come a long way by adopting a Constitution and Bylaws. This document has set up a board of directors comprising all county officers, Indiana State Medical Association delegates from the Twelfth District and the district officers. The board meets four times a year. It has been quite successful in starting and carrying out the ideas outlined in the first paragraph of this report. There is still much work to be done so that (with all counties working together) the Twelfth District will become a unified force in developing the purpose of our organization as outlined in our new Constitution and Bylaws.

Our annual meeting was held on May 21st at the Club Olympia, Fort Wayne, Indiana. The meeting was well attended and the following guests were present:

Ralph Everly, M.D., chairman of the Executive Committee of the ISMA; Burton Kintner, M.D., member of the Executive Committee of the ISMA; Malcolm Scamahorn, M.D., assistant treasurer of the ISMA; Donald Taylor, M.D., Eighth District trustee and chairman of the board; Peter Petrich, M|.D., Ninth District trustee; John Butler, M.D., Seventh District alternate; Otis Bowen, M.D., Thirteenth District trustee; Mr. James Waggener, executive secretary of the ISMA and Mr. Howard Grindstaff, field secretary of the ISMA.

Dr. Kenneth Isenogle, president of the Twelfth District, presided. New officers named were John Hartman, M.D., Angola, president; Robert Edwards, M.D., Auburn, vice-president; DeWayne Hull, M.D., Fort Wayne, secretary-treasurer and Kenneth Isenogle, M.D., Fort Wayne, elected to fill the unexpired term of Dr. Mahlon Miller on the Blue Shield board.

The new Constitution and Bylaws was adopted after several changes were made in the original that had been drafted by

the officers and board of directors. Reports were given by the officers and a typewritten report of my activities, as well as future plans for the association as trustee, was made available to all in attendance.

That evening we were treated to a panel discussion on the subject, "Indiana Medicaid—Friend or Foe?"

The panel participants were Eugene Senseny, M.D., state delegate to the American Medical Association, acting as moderator; Otis Bowen, M.D., Thirteenth District trustee and Speaker of the House of Representatives of the Indiana State Legislature; Floyd Coleman, M.D., state representative from DeKalb County and Mr. William Sterrett, administrator of the Indiana Department of Public Welfare.

This was a very informative discussion and was much appreciated by all. My thanks to those participating.

I also want to thank the out-going officers for their leadership and co-operation during the past year. I want to express my deep appreciation to Dr. Fred Schoen, my alternate. His wise counsel has been a great aid to me. (P.S. Fred has never missed a meeting.)

Along with the officers of the district, I look forward to the challenges of the new year. With their help and that of our new board of directors, I am sure the Twelfth District can and will successfully meet the challenges of the rapidly changing times in the practice of medicine.

WILLIAM R. CLARK, SR., M.D.,
Trustee

Thirteenth Trustee District



OTIS R. BOWEN, M.D.,
Trustee

The annual meeting of the Thirteenth District Medical Society of Indiana is scheduled for Sept. 17th, 1969. It is in the planning stage at present. By the time this report is published and read, the meeting will already have been held; therefore no further comments concerning it are indicated.

The most important item to report concerns the status of comprehensive health planning in the Thirteenth District. All counties are either organized and functioning as a county unit in a proposed region, are part of a proposed region but without a county organization, or are part of a region and are forming a county organization in addition.

LaPorte, St. Joseph and Kosciusko counties are each organized as a county and are functioning in a proposed region; Starke and Marshall counties are part of a proposed region but without a county organization; and Fulton and Pulaski counties are part of a proposed region and are forming their own county organization.

During the past year there were five doctors in the district whose dues were remitted because of illness or retirement from practice or because of service in missionary work with each of these reasons causing hardship on the individual doctor.

OTIS R. BOWEN, M.D., *Trustee*

Editor of The Journal

The Journal is experiencing another good year. All functions, with the possible exception of financial, are in good order.

Advertising revenue has been less than expected, but the size of each issue has been adjusted to compensate for this. Expenditures for items other than printing have been minimized. At the end of the first nine months of the fiscal year, we had a small positive dollar balance, before taxes.

The indeterminate element in the finances this year is the federal advertising revenue tax. The Internal Revenue Service has ruled that the sale of advertising space by a publication of a tax-exempt organization is a transaction which is unrelated to the purposes for which the organization is granted its tax-exempt status and that the revenue from such sale is subject to taxation.

Certain expenses of selling, processing and publishing the advertising may be deducted from the gross revenue to determine the net amount which is taxable. At the time of this writing the association has not been able to obtain a legal opinion in regard to the method of determining the taxable net amount, and cannot predict what the tax obligation will be.

It is possible that our total advertising income for the fiscal year will equal or approach that for last year. The first half of the year was down by some 25% but this summer has been the best ever and may cure the shortage accumulated during the winter months.

The scientific content of *The Journal* has been supported admirably by a large number of short and practical articles of clinical importance. Authoritative review and original essays have been contributed by members of the faculty of Indiana University School of Medicine and the Krannert Institute of Cardiology.

Special articles on the Heart, Cancer, and Stroke Program, Comprehensive Health Planning, and Medicaid have been included for the information of the profession.

FRANK B. RAMSEY, M.D.,
Editor

Delegates to AMA

Delegates to an AMA convention have never been busier than they were at the 118th Annual Convention in New York July 13 through 17.

During 15 hours and 40 minutes the House was in session, not including the inaugural ceremony, delegates heard a 20-minute speech by the Vice President of the United States; heard a 25-minute informal address by the newly appointed Secretary of HEW for Health and Scientific Affairs; heard the final report of President Dwight L. Wilbur; presented a special award to the medical staff of NASA's Manned Spacecraft Center in Houston; listened to reports from AMPAC, AMA-ERF and SAMA; roundly applauded President Gerald D. Dorman Thursday morning for not delivering his first report to the House, but instead distributing it for delegates to read; and still found time to act on an all-time record of 196 items of business—an average, even with everything else going on, of one vote every four minutes and 47 seconds.

Business presented to the House included 59 reports from the board of trustees; the executive vice president; and standing and special committees; and 137 resolutions, four of which were memorials and one a commendation of President Wilbur.

Of the 59 reports, the House adopted 30; adopted and referred one; amended and adopted five; approved 17; and accepted two for information. Four required no House action.

Of the 137 resolutions, 17 were adopted; 28 were adopted as amended or a substitute was adopted; 30 were referred, with or without amendment; 44 were combined with one or more other resolutions before action was taken; one was partially adopted and partially referred; 15 were rejected; and two were withdrawn.

Elections

After a nominating speech and seconds by 18 delegates, Walter C. Bornemeier, Ill., was elected president-elect by acclamation. He will become the AMA's 125th president at the Annual Convention of 1970 in Chicago.

The House unanimously elected M.

Louise Gloeckner, Pa., as vice president; and Russell B. Roth, Pa., as speaker of the house.

J. Frank Walker, Ga., was elected vice speaker of the house.

In the election of trustees, Burt L. Davis, Calif.; Burtis E. Montgomery, Ill.; and Max H. Parrott, Ore., were unanimously re-elected. Charles A. Hoffman, W. Va., was elected to the trustee position vacated by Edward R. Annis, Fla.

Election to councils was as follows:

Constitution and Bylaws: Robert M. Tenery, Tex.

Medical Education: Joseph M. White, Tex., and William A. Sodeman, Pa.

Medical Service: John M. Rumsey, Calif., Richard E. Palmer, Va., and Donald R. Hayes, Mass.

Judicial Council: Charles C. Smeltzer, Tenn.

Vice President's Address

Vice President Spiro T. Agnew began his remarks with some very nice words about the medical profession.

"I can sympathize with those of you who, after struggling for years to improve the health of this nation, now find few kind words written and few voices raised in your defense.

"I believe that your record speaks for itself. I think that millions of Americans who appreciate their family doctors and value the doctor-patient relationship know your work.

"So many opinion leaders nit-pick against the profession which, in this century, added more than 20 years to life expectancy; a profession which has virtually eliminated so many fatal, crippling and debilitating diseases in this country and around the world.

"Our medical profession has achieved this," he said, "not our politicians and not our press. And we betray every doctor, in and out of the AMA, when we deprecate your dedication."

The theme of Mr. Agnew's speech was pollution. "While enlightened man refuses to accept disease, he tolerates the erosion of his environment. Intelligent Americans who will not live in unpleasant surroundings among hostile people, endure with bland indifference mildly poisoned air, polluted waters and noise just below the pitch of madness. A nation capable of catapulting men to the moon is in mortal danger of devouring its irreplaceable, life-sustaining elements."

He described a number of anti-pollution programs being undertaken or planned by the federal government, in cooperation with the states and the private sector, and emphasized that "Private professional organizations like the AMA will have a role to play in encouraging environmental improvement. Your increasing voluntary participation at the state and local level can result in greater public support to enlarged programs."

He ended by saying, "We feel we act upon a mandate as fundamental as the problem itself. It's the first mandate of humanity: the right to survive."

Dr. Egeberg's Remarks

Dr. Roger O. Egeberg, Assistant Secretary of HEW for Health and Scientific Affairs, talked about the rising cost of health care, advances in medical science and the fact that physicians are working long, hard hours. "However," he said, "I don't want to sound soft on doctors. I don't want to sound soft on organized medicine. I do feel that there has been a principle that has been ignored perhaps more by organized medicine than it should be. And it comes, I think, from the ethics of Hippocrates, who preached that you should take care of those who came to you; those within your purview.

"I would think that is probably a very good ethic to follow. But we have to add something to it. And that is the ethic that as a group we must look around. We must see that there are people not in front of us who need help.

"The poor live utterly differently from us. But we have created a distribution of medical care in a way that suits us and suits the middle class.

"Now, in order to reach [the poor], we've got to find new ways of distributing medical care."

After some elaboration on those points, he closed by saying, "I would hope that the government will be able to cooperate with the people who are delivering the medical care; will take them into confidence; will discuss the solution of the problems. Because we have come to a crisis. We have to solve it. The more heads we can get at it, the more feeling of 'this is our problem' will exist. And if we can feel that it is our problem, rather than 'theirs,' I think we can solve it."

President's Final Report

In his report to the opening session of the House, President Wilbur said that physicians must have clinical sense, social sense and common sense.

Under clinical sense, he predicted that the greatest scientific advances will be in three areas: "Understanding and perhaps partial control of degenerative diseases; a substantial gain in knowledge and control of psychiatric disorders; and the control of reproduction, with better human and medical understanding of contraception, abortion, population control and control of those genetic characteristics to be most valued by humanity."

Under social sense, he asked, "Will we ever see a lessening of public interest in medicine and health? Will voluntary health agencies, social and welfare groups, planning bodies in the health field and public health groups lessen their great and growing interest in the development and application of knowledge in health or in medicine? Today, and even more in the future, health and medicine are not matters just for physicians and patients. They are matters of total public concern."

In this part of his talk, he discussed the removal of barriers to medical care and the need for more ambulatory care of patients, emphasizing the potential value of community health centers.

In the final section, he pointed out that "Tempering our clinical sense with a social sense is good common sense. It will be so recognized by the public.

"Changes in medicine and medical care," he said, "will best be made by evolutionary rather than revolutionary and disruptive change, aside from the rare, great discovery or invention in medical science."

He concluded with these words: "We can meet the health needs of the American people but we cannot meet them alone. While our knowledge of health may be unique and indispensable, our desire to serve all of society is matched by many of its other elements. We must lead, but our leadership must continually be earned. It cannot be assumed.

"As we look to the future, we must constantly ask ourselves the right questions and try to find the right answers — answers based, as often as possible, on fact and experience and tempered to the needs of people in a rapidly changing society."

Inaugural Address

After taking the oath of office as the 124th President of the AMA, Gerald D. Dorman listed three goals "which our House of Delegates has accepted on the road to our main objective, the best possible health care to all our patients who need it.

"One, a constantly advancing health care system in America. Two, a widespread respect for the leadership, and a widespread recognition of the contributions of the medical profession. And three, enhanced functioning of the medical profession."

The first goal, he said, must be "based on incentives and freedom of opportunity. Incentives are needed for people to stay healthy, for physicians, hospitals and allied professionals to increase care and hold down costs."

As to the second, he said, "We know that it is in the best interests of the nation's people that physicians maintain and strengthen their leadership in all matters pertaining to health care. To do so, however, we must perform at a height beyond any level achieved before.

"We must, besides earning the position of leadership, be worthy of the respect that goes with it. The profession must be above all suspicion. This means that we must maintain a visible sincerity and dedication in our profession."

About the third, "I would mention enhancement of the functioning of the medical profession by more effective communication within the profession, with the allied health professions, with influential groups of our citizenry, educators, clergy, business men, labor, lawyers, civic leaders and leaders of government on all levels."

He concluded by stating that "The problems that exist in medical and health care for the people of our nation will not be solved overnight. Nor will they be solved in a month or a year. But solutions—at least, proposals and experiments to find solutions—will be forthcoming."

First Report to the House

Because of the volume of business and the shortage of time on the final day of the convention, President Dorman announced to the House that he would not deliver his first report. Instead, copies were made available to the delegates to read at their leisure.

In the report, Dr. Dorman pointed out that the physician has distinct advantages in the satisfaction he gets from his profession, and the honor in which he is held by other people. He also pointed out that as the penalty of professionalism, "we must willingly accept not only the respect it brings us, but also the obligation to be deeply and actively concerned with every facet of health and health care. There is no aspect of health, direct or remote, that is not our responsibility, in whole or in part."

He then listed problems and showed what the AMA is doing about them now and suggested other things that might be done. Included were quality of medical care; physicians who cheat on government financing programs; providing care, for the poor; sex education; maternal and child care; and methods of delivering medical and health care.

All of those problems, "as health matters, require action. All of them, as health problems, demand solutions. I am confident the solutions will come and that they will come—principally through the deliberations and the programs of the American Medical Association and all of the medical profession and its allies. We cannot delay. We must meet the demanding obligations which are the penalty of our leadership in medical and health care."

ACTIONS OF THE HOUSE OF DELEGATES

As a matter of convenience, actions taken by the House will be listed here in the order in which they were presented to the House by the various Reference Committees.

Reference Committee on Amendments to Constitution and Bylaws

AMA Membership for Osteopaths: In response to a House directive at the Clinical Convention, 1968, that qualified osteopaths be admitted to full active membership in the AMA, the House amended the first paragraph of Chapter I, Section 1 of the Bylaws as follows:

> (A) Regular Members—Regular membership shall be limited to those members of a state medical association who hold the degree of Doctor of Medicine or Bachelor of Medicine, or who hold an unrestricted license to practice medicine and surgery, and are entitled to exercise the rights of membership in their state medical associations, including the right to vote and hold office, as determined by their state medical associations.

Scientific Sections: The Ad Hoc Committee to Study the Modus Operandi of the Scientific Sections reported its belief (which the House adopted) that the AMA can achieve greater unity within the medical profession and further strengthen its scientific program by inviting the national medical specialty societies to play a more active and responsible role and giving those societies a privilege of participating in the selection of section delegates in the AMA House and other section officers.

The scientific assembly will be divided into these specialty sections:

Allergy
Anesthesiology
Clinical Pharmacology and Therapeutics (formerly Experimental Medicine and Therapeutics)
Colon and Rectal Surgery
Dermatology
Diseases of the Chest
Family and General Practice (formerly General Practice)
Gastroenterology
General Surgery
Internal Medicine
Military Medicine
Obstetrics and Gynecology
Ophthalmology
Orthopedic Surgery
Otorhinolaryngology
Pathology (formerly Pathology and Physiology)
Pediatrics
Physical Medicine and Rehabilitation (formerly Physical Medicine)
Preventive Medicine
Psychiatry and Neurology (formerly Nervous and Mental Diseases)
Radiology
Special Topics
Urology

AMA Bylaws, Chapter VII, Sections 3-9, are to be rewritten to effect these changes, among others:

Each section will establish a section council. After the 1970 Clinical Convention, medical specialty societies will be invited to help form section councils.

Membership of the section councils "shall be selected by the national specialty societies listed in the American Medical Directory apportioned on the basis of the number of AMA members belonging to each specialty society and one member to be elected by the scientific section from the section membership."

At the 1971 Annual Convention, establishment of AMA section councils will be reported to each specialty section. The councils become effective January 1, 1972. All section councils will be under the direction of the Board of Trustees and will be governed by rules established by the Board and approved by the House.

Reference Committee A

Cost of Care: The House stated that "The physician's influence on the costs of health care will be in proportion to his conscious efforts to adhere to practices which conserve the resources of his patient. As the provider of medical service, the doctor has a significant and responsible role in any organized effort to control health care expenditures. In this role, the physician has a challenge to maintain and improve a system that best serves the public and is most acceptable to him and to the profession of which he is a part."

Medicare and Medicaid: In connection with reducing medicaid costs, the House

adopted a report listing four action programs of the profession: expanded peer review programs by county medical societies to reduce hospital and nursing home care and to expand ambulatory care; eradication by the profession of isolated abuses by physicians; promotion of innovative health service delivery systems for low income communities, with emphasis on ambulatory care; and programs by local medical societies to preserve quality of care in the face of cost containment measures.

With respect to physician payment in teaching situations, the House resolved that the Board of Trustees "take action to evaluate and effect improvement of the regulations in keeping with the intent of Medicare and Medicaid in relation to teaching situations."

On the subject of medicare fees and fee schedules, the House said, "While the AMA has not taken a specific position on the procedures relating to the development and application of physicians' fees profiles and prevailing charge screens, the actions which have been taken by the House would indicate that these concepts as defined through directives of the Social Security Administration, are not consistent with policies of the American Medical Association."

The House also said that since "Actions taken by DHEW to set rigid limits on levels of payments to physicians who provide services under Medicaid appear in contradiction to Congressional intent that Medicaid patients receive care on the same basis as private patients," it resolved that the AMA "urge a reassessment by Congress of its intent and priorities in relation to Title XIX."

Regarding the isolated abuses of government programs, the House resolved that the Board's "efforts to obtain access to information referable to alleged misuse of any programs of health care be commended" but added that "In the publicizing of charges without the availability of reasonable and specific facts concerning individuals, the result is detrimental to the best interests of American medicine."

Voluntary Health Insurance: The House adopted a report urging that state medical association county societies and physicians individually direct "unstinting effort" to promote the proposed program of income tax credits for financing health care and "publicize the advantages inherent in this approach to preserve and strengthen the voluntary system."

Delegates also resolved that the AMA "encourages the development of prepayment medical insurance programs in which the payment to the physician is based upon the usual, customary or reasonable fee concept" and that "any reference to 'paid-in-full' coverage clearly identify those services which are indeed covered on a 'paid-in-full' basis and also identify the circumstances under which those services must be rendered."

Billing Procedures: "To ensure the continuance of the one-to-one physician-patient relationship," the House stated, "the profession considers direct billing preferable—identifying Medicare primarily as a financial aid to the patient. As long as Medicare holds to a realistic assessment of 'reasonable charges,' there will be comparatively few instances when direct billing entails greater out-of-pocket payment by the patient than does assignment."

Peer Review: This statement was adopted by the House: "The Council on Medical Service knows of no greater challenge facing the profession today than to secure universal acceptance and application of the peer review concept as the most meaningful method for creating a public awareness of medicine's efforts to assure high quality of health services at a reasonable cost."

Comprehensive Health Planning: The House said, about comprehensive health planning, that "Certainly, physicians and their professional organizations must accept the responsibility of working in the planning group throughout all stages of planning in order to provide guidance in choosing goals and programs that will realistically meet the community's needs;" and further resolved that "financial reimbursement for health care be based on the adequacy, competency and efficiency of patient care and not on the basis of approval by any regional planning agency."

Reference Committee B

Medical Care as a Right: To make its position clear in the long-standing discussions of medical care as a right, the House resolved that it "reaffirm its position (1) that it is a basic right of every citizen to have available to him adequate health care; (2) that it is a basic right of every citizen to have a free choice of physician and institution in the obtaining of medical care; and (3) that the medical profession, using all means at its disposal, should endeavor to make good medical care available to each person."

Government Reports: The House resolved that "the American Medical Association make every effort to secure appropriate payment to physicians for complex and detailed reports prepared for use by governmental agencies." This resolution does not affect the 1965 Judicial Council opinion that simplified insurance forms be completed without charge.

Extended Care: Because of the higher cost of hospitalization, the House resolved that the AMA "be urged to seek changes in the medicare law to allow direct admission to extended care facilities when edigible patients' conditions require less than acute hospital care."

Reducing Paper Work: Recognizing the avalanche of paper that threatens to inundate physicians, the House resolved that the AMA and state medical associations "undertake new discussions with governmental agencies, insurance companies and hospitals with the objective of achieving substantial reductions in the amount of paper work—hopefully amounting to at least a one-half decrease—and thus reducing the cost of health care and enabling physicians to devote the maximum time and effort possible to the care of patients."

Reference Committee C

Private Practice: A resolution that the AMA "establish a Council on Private Practice, with the primary objective being to espouse the aspirations and goals of private practice" was adopted by the House and referred to an ad hoc committee to be appointed by the speaker of the house.

Federal Support of Medical Schools: In a change of House policy regarding federal loans to medical students, a joint report of the Board of Trustees and the Council on Medical Education was approved which calls for an increase in financial support of medical schools by the federal government to permit a major increase in the enrollment of medical students and the production of physicians. The change was considered justified because of current fiscal conditions which make it increasingly difficult for students to obtain loans from the private sector as a result of high interest rates and a restricted supply of money for personal loans.

Relicensure: The House approved a report recommending that "the physician's continued competency to provide quality health services be maintained by every practical means available; that a relicensure program not be considered at this time; that peer group evaluation be continually utilized and improved; that methods of improving the availability and the content of continuing education programs be continually investigated and refined; that additional incentives be positive in nature and come from within the profession."

Educational "Essentials": The House approved essentials of an accredited educa-

tional program in nuclear medical technology; revision of essentials of approved residencies in thoracic surgery, neurology, anesthesiology and general requirements; revision of essentials of approved internship to provide for participation of osteopaths; revision of essentials of approved residencies pertaining to osteopaths; and essentials of an accredited educational program for medical assistants.

Reference Committee D

Health Care of the Poor: The House adopted the report of the Board of Trustees' Committee on Health Care of the Poor, which reiterated "our strong commitment toward expanding nationwide programs to improve the health of the poor" and stated that "the same quality of medical care should be accessible to all people."

The committee listed "certain concepts that we believe must be included in the association's program:" (Paraphrased and condensed.)

1. Providing comprehensive health care to the poor is a desirable goal.
2. It must be a continuing program, identifying both short-range and long-range activities.
3. The committee's purpose must be to implement the research that has been done on unmet needs for health services.
4. Program must provide for participation of the poor in planning projects for their communities.
5. Physicians should work with numerous other organizations, both in and out of the health field, that have expressed concern about improving health care of the poor.

The committee concluded by stating that it "recognizes that the problems for which it hopes to find solutions are too critical and too complex for superficial, cursory answers. It believes that dynamic action in this field must have a top priority in the American Medical Association's activities."

Physicians and Hospitals: Most items considered by this Reference Committee had to do with physicians, hospitals and the JCAH.

For example, the House resolved that "the AMA Commissioners to the JCAH urge the joint commission to insure that that body which carries out the governing function of the medical staff shall be representative of the medical staff, both hospital-based and voluntary, and that this body shall advise the governing board of the hospital on policy regarding medical judgment and skill and on matters relating to the bylaws, rules and regulations of the medical staff."

The House also resolved that the AMA urge the JCAH "to give approval to effective staff and section meeting structures which combine two or more hospitals with overlapping medical staffs within a logical geographical area."

Reference Committee E

Full Disclosure of Laboratory Billings: The House adopted a Judicial Council report, "Review of Ethical Considerations Relating to Clinical Laboratories," which ended with this paragraph: "Where it is necessary for the attending physician to bill his patient for services performed by a clinical laboratory, the bill submitted by the attending physician to his patient should state the name of the clinical laboratory performing the services for his patient and state the exact amount of the laboratory charge paid or to be paid by the physician to the clinical laboratory."

Also adopted was the resolution that the "attending physician is entitled to fair compensation for the professional services he renders. He is not engaged in a commercial enterprise, however, and any markup, commission or profit on the services rendered by a laboratory is exploitation of the patient."

Blood Donors: The House encouraged "state medical associations to actively promote state legislation to provide that persons age 18 or over may donate blood without the necessity of parental permission or authorization and without restriction to voluntary or non-compensatory blood donation programs."

Prescription Labeling: Two resolutions concerning the labeling of prescriptions were referred to the Board of Trustees and the Council on Legislative Activities, after being adopted by the House. One recommends legislation requiring labeling; the other encourages labeling.

Reference Committee F

Financial Report: The AMA's financial statement for the year ending June 30, 1969, was approved and the House then resolved that "the Finance Committee of the Board of Trustees meet in advance of each annual convention with the Reference Committee to which the annual financial statement will be referred for presentation and discussion of more detailed budget and financial data of the association, so that the Reference Committee will be able to make a more meaningful evaluation for the House of Delegates."

AMA Management Survey: The House adopted the management survey report of Cresap, McCormick and Paget and approved the analysis of communications made by the Philip Lesly Company.

In connection with the former, the House approved the Reference Committee's list of eight subjects to which "the highest priorities in activities and programs should be assigned:"

1. The rising cost of health care.
2. The expansion of out-of-hospital health services.
3. The development of community health centers.
4. Experimentation and innovation on new methods of delivery of health services.
5. Medical audit, utilization and review committees.
6. Medical manpower needs.
7. Preventive medicine.
8. Family planning.

The House also requested that the Board of Trustees (1) develop program priorities; (2) outline specific techniques of resolving the problems caused by those priority programs; and (3) report to the House at each semi-annual session on progress being made.

State Projects of AMA: The House resolved that "financial support by the AMA for local or area health service projects should be preceded by consultation with the constituent association of the state or states in which the projects are to be conducted."

Professional Liability: In connection with professional liability, the House adopted the following statements as recommendations of the AMA:

1. First, that constituent associations "seek the enactment of appropriate state legislation designed to provide a more efficient and equitable determination of malpractice claims and litigation."
2. Second, that state associations, with the help of AMA, "seek the cooperation of hospital associations and third party payers in exploring and developing, if feasible, pilot programs which will provide scheduled benefits for persons injured as a consequence of medical accidents occurring in the delivery of health care, irrespective of fault."
3. Third, "that workshops on malpractice insurance problems be conducted, as requested by the Board of Trustees, in which participation will be invited from (1) physicians confronted by insurance problems, (2) representatives of the insurance carriers, (3) staff attorneys of AMA and other appropriate staff personnel, (4) representatives of and attorneys for the hospital service field, (5) nurses and (6) legislators."

In addition, the House resolved that the AMA "should not attempt to establish a nationwide professional liability insur-

ance program either by sponsorship of a program underwritten by an existing insurance carrier or by seeking to establish a new insurance carrier."

Reference Committee G

Sex Education: While recognizing "that the primary responsibility for family life education is in the home," the House supported "in principle the inauguration by State Boards of Education or school districts, whichever is applicable, of a voluntary family life and sex education program at appropriate grade levels:

"(1) as part of an overall health education program;

"(2) presented in a manner commensurate with the maturation level of the student;

"(3) following a professionally developed curriculum foreviewed by representative parents;

"(4) including ample and continuing involvement of parents and other concerned members of the community;

"(5) developed around a system of values defined and delineated by representatives comprising physicians, educators, the clergy and other appropriate groups; and

"(6) utilizing classroom teachers and other professionals who have an aptitude for working with young people and who have received special training."

Nursing: The House reaffirmed "its support of all forms of nursing education including baccalaureate, diploma, associate and practical nurse education programs" and encouraged "the continuation of federal, state and local subsidies to schools of nursing education."

Smoking and Health: The House resolved that the AMA "again urge its members to play a major role against cigarette smoking by personal example and by advice regarding the health hazards of smoking" and "discourage smoking by means of public pronouncements and educational programs." It also resolved to "indicate to the Congress of the United States the incongruity of the expenditure of tax dollars to promote the production and sale of tobacco while at the same time spending other tax dollars to discourage cigarette smoking because of its hazard to health."

Food Mixes: The House requested the U.S. Food and Drug Administration to "favorably consider the proposal of the Council on Foods and Nutrition regarding labeling of fatty-acid composition" of food mixes, and that the Council on Foods and Nutrition "undertake the development of a rational proposal for identifying and labeling other nutritionally significant components of convenience foods."

Protective Headgear: The Committee on the Medical Aspects of Sports was asked by the House "to continue its efforts to utilize and publicize existing research and recommendations on football helmets to assure optimum protection for players against impacts which cause head and neck injuries" and "to do everything possible to discourage the practice of 'spearing.'"

Reference Committee H

Highway Signs: A Board of Trustees report and a resolution were adopted recommending a uniform system of highway directional signs designating emergency medical facilities. However, the House pointed out clearly that "this action does not encourage or approve the use of the copyrighted AMA symbol for other unauthorized and unidentified programs."

Credit Cards: Two resolutions concerning the use of credit cards to pay for medical care were referred to the Judicial Council for information, "with the expectation that additional opinions will be rendered as experience accumulates." In certain states, the Reference Committee pointed out, a charge card system is under experimentation by the state medical society and is deserving of a chance to prove its merits. Also, the Judicial Council has ruled that the use of a charge card system should be flexible and at the discretion of the individual state medical societies.

Medical Instruments and Devices: Pointing out that legislation related to federal standards to regulate the use of medical instruments and devices was introduced in the 90th and 91st Congresses, the House resolved that the AMA "be commended for its position supporting the concept of a thorough study of the field of medical instruments and devices prior to passage of specific regulatory legislation."

Unification Through AMA: The House resolved that the Board of Trustees be asked to begin a study "of physicians who are not members of the AMA, and then make recommendations to the House of Delegates and to the state and county societies, as to how the medical profession may more wisely unify itself under the AMA banner, and encourage non-participating physicians to join."

Presentations, Awards and Announcements

Robert E. Gross, M.D., was presented the Dr. Rodman E. Sheen and Thomas G. Sheen Award. Dr. Gross is Ladd Professor of Children's Surgery at Harvard Medical School and director of cardiovascular surgery at Children's Hospital Medical Center, Boston.

Charles A. Berry, M.D., medical director of the NASA Manned Spacecraft Center in Houston, was presented a plaque: "The American Medical Association presents this citation for distinguished service to medicine to Charles A. Berry, M.D., and the medical staff of the Manned Spacecraft Center, NASA, at Houston, Texas, in recognition of their efforts in solving the difficult and complex problems of assuring the health and contributing substantially to the safety and survival of the astronauts participating in the United States space exploration program."

Stephan R. Chernay, M.D., New York, received the first AMA recognition award for continuing education.

Executive Vice President E. B. Howard announced to the House the appointment of Richard Wilbur, M.D., Calif., as Assistant Executive Vice President of the AMA. An Assistant Executive Vice President for Scientific Affairs also is to be named.

The medical winners in the 20th International Science Fair for high school students were introduced to the House and their exhibits were included among the scientific exhibits at the convention.

They were Cathy Jennemann, 16, a junior at Monte Cassino High School, Tulsa, Okla., whose exhibit was "Possible Deafness From Everyday Noise;" and Greg Kauffman, 16, a junior at Albuquerque (N. M.) High School, "Pyelonephritic Recurrence."

Interruption

The House suffered a 21-minute interruption during its opening session Sunday when 30 to 40 dissident medical students and their friends, many with beards, some wearing white smocks, seized the podium and demanded the right to address the House.

The news release they distributed identified them as representatives of the Student Health Organization, the Medical Committee for Human Rights, the Movement for a Democratic Society, the Health Policy Advisory Center, the Rockefeller University Committee for a Democratic Society "and many others."

The group's spokesman began by declaring the meeting "illegal and illegitimate" and ended by burning what he called his AMA membership card, but which television news described as a Blue Shield card.

He came back Wednesday with a "nonnegotiable demand" for 10 minutes to speak during the inaugural ceremony, but was flatly refused by the Reference Commitee on Rules and Order of Business.

GUY A. OWSLEY, M.D.
JACK E. SHIELDS, M.D.
DON E. WOOD, M.D.
EUGENE F. SENSENY, M.D.
FRANK H. GREEN, M.D.

Reports of Committees

Executive Committee

The Executive Committee has met regularly throughout the year, usually with a full attendance of all members. I think it is unnecessary to go into great detail as to the activities of our committee inasmuch as the minutes have been published regularly in *The Journal* and widely distributed. Also copies of all minutes are being made available to the Reference Committee for their review.

However, in addition to the normal routine housekeeping responsibilities of the committee, I would like to call your attention to just a few of the matters handled by the Executive Committee during the past year.

(1) Recommended to the Board of Trustees the installation of a 24 hour recording service.

(2) Recommended to the Board of Trustees that cooking equipment be installed in the basement of the building.

(3) Recommended to the Board that the officers of the association take a course in public speaking.

(4) Approved certificates for presentation to past AMA delegates and members of the association who have served on the Council and other officers.

(5) Offered secretarial services to specialty groups of the state.

(6) Referred two delinquent student loan accounts to legal counsel for collection.

(7) Referred to Commission on Emergency Medical Services, for their review and report, "Changes in Standing Orders for Emergency Rooms of Hospitals."

(8) Authorized proposed resolutions for presentation at the American Medical Association Clinical Session.

(9) Referred to the Board a request that the association establish a Sports and Medicine Committee.

(10) Met with Indiana delegation to the American Medical Association meetings.

(11) Authorized the president to establish an Advisory Committee to the President.

(12) Recommended the establishment of a policy of having candidates for offices in the American Medical Association to appear before the Indiana delegates and the Executive Committee prior to election for their various offices.

(13) Recommended to the Board that a survey be made concerning the backlog of payments to M.D.'s by welfare and township trustees.

(14) Referred to the Board problems of county society attempts to obtain usual and customary fees in welfare contracts.

(15) Voted to support the Youth Power Conference and the Health Careers program.

(16) Referred to the Board a resolution supporting the establishment of a medical examiner system by the state legislature.

(17) Referred to the Board for their consideration a recommendation that new members pay a $50 entrance fee for supporting the upkeep of the building.

(18) Reviewed all legislative matters referred to the committee by the Commission on Legislation.

(19) Authorized the re-establishment of the County Society Officers Conference.

(20) Reviewed the action of the Oklahoma Medical Association requiring their members to complete 30 hours of postgraduate work annually as a basis for continuing membership.

(21) Referred to the Board the suggestion of changing title of executive secretary to a title in keeping with other organizations.

(22) Referred to the Board the question of the past president being included as a part of the Indiana delegation to the American Medical Association.

(23) Held two joint meetings with the Executive Committee of the Indiana Hospital Association for discussion of mutual problems.

(24) Recommended to the Board of Trustees that they study the financial needs of the association and consider making a recommendation of a $5.00 annual dues increase instead of waiting and then having to make a sizeable dues increase at one time.

(25) Authorized purchase of kits on "Defense Against Quackery" for distribution at Regional School Health Conferences.

(26) Approved renewal of membership in the United States Chamber of Commerce.

(27) Welcomed American Medical Association Council on Voluntary Health Agencies to hold a 12 state regional meeting in Indianapolis October 11 and 12.

(28) Approved the suggestion of the president to establish a meeting of hospital chiefs of staff, hospital administrators and trustees and authorized the president to work out the program.

(29) Recommended to the Board of Trustees that they study the idea of recommending an amendment to the Constitution and Bylaws that all elections held at the county and district level be done by mail ballot.

(30) Accepted an offer of the A.H. Robins Company to supply an award to a physician for his community service.

(31) Approved a substandard insurance program as recommended by the Commission on Medical Economics and Insurance for offering to members who could not qualify for the present program.

(32) Approved the establishment of a joint advisory committee to be composed of hospitals, insurance companies and physicians for the purpose of resolving insurance problems.

(33) Ordered distribution of American Medical Association definition of "usual", "customary", and "reasonable" to all Indiana insurance companies.

(34) Referred to the Board of Trustees a letter from the State Health Commissioner concerning the change in the use of silver nitrate in the eyes of the newborn.

(35) Approved a request of the Board of Health for plans for distribution of RH_o (D) Immune Globulin-Human.

(36) Requested republication in *The Journal* of the Medical-Legal Code.

(37) Approved the suggestion of the president that he contact non-members urging them to join their county society, the state association, and the American Medical Association.

(38) Approved the executive secretary serving on an advisory committee for the program on Emergeney Medical Services.

(39) Referred to the Board the question of air conditioning of the building.

You will see from this abbreviated rundown, which does not begin to cover the matters which came before your Executive Committee, it is evident that your committee has had a busy year.

Medical Defense Activities

1. *Malpractice Cases.* A year ago, at the time of this report, August 1, 1968, the following four cases were pending before the committee:

Case 307—Suit filed March 22, 1962. Pending. (Expense to date $1,042.73).

Case 309—Suit filed December 10, 1964. Pending.

Case 312—Suit filed December 7, 1965. Pending.

Case 313—Suit filed September 5, 1967.

Since August 1, 1968, and up to August 1, 1969, no new cases have been filed.

2. *Medical Defense Fund Statement from August 1, 1968 to August 1, 1969:*

Bank Balance,		
August 1, 1968		$3,153.79
Investments,		
Treasury Bonds		25,000.00
		28,153.79
Receipts:		
Dues	$4,998.75	
Interest	960.53	
		5,959.28
Total cash and receipts +investments		$34,113.07
Disbursements:		
Attorney Fees	$3,848.61	
		3,848.61
Balance on hand August 1, 1969		$30,264.46

The Journal

The financing problems of *The Journal* remains one of our biggest headaches. What we have gained in reduction of production costs has been offset in the drop in revenue from advertising. The advertising continues to fluctuate and at the rate we are going for '69, the income from advertising may be one of the lowest since 1966. Despite the financial situation, it does not seem prudent to lower the standards of *The Journal*, which is recognized as one of the best state journals published.

Listed below is a comparative report of *The Journal* operations over the past several years and the first six months of 1969.

Below are figures revealing price per page increases of *The Journal* (excluding inserts)

1965	$2.54	
1966	$2.96	
1967	$3.45	
1968	$3.47	
1969	$3.19	(First six months)

The table below shows the total printing costs of *The Journal*:

Year	Total Printing Cost	No. of Pages (Inserts excluded)
1965	$35,957.50	1416
1966	$41,795.32	1410
1967	$49,958.15	1450
1968	$50,709.62	1463
1969 (6 months)	$21,042.28	660

The following table shows the number of journal pages for the past six years (includes inserts).

Year	Reading	% Reading	Adv. Pages	% Adv. Pages	Total Pages	Av. Pages per Issue
1963	1139	70	487	30	1626	135
1964	1051	71	423	29	1474	123
1965	998	68	464	32	1462	122
1966	789	50	781	50	1570	131
1967	1041	58	751	42	1792	149
1968	1068	61	696	39	1764	147

Advertising volume for the first six months of 1969 is down. We are hopeful that in the month of September, which is forecast as a good advertising month, that advertising might increase sufficiently to offset the loss of most of the income for the first six months and bring us up to a figure more nearly equal to those of previous years.

A comparison of advertising revenues for the first six months of the last four years, with a like figure for 1969 is as follows:

	1965	1966	1967
State Medical Journal Adv. Bureau	$13,927.88	18,069.54	23,468.96
		1968	1969
		24,153.24	17,086.59
	1965	1966	1967
Sold Direct by Journal	$2,812.74	2,687.76	3,056.68
		1968	1969
		7,200.10	2,557.80
	1965	1966	1967
Total	$16,740.62	$20,757.30	$26,525.64
		1968	1969
		$31,353.34	$19,644.39

RALPH V. EVERLY, M.D., *Chairman*
BURTON E. KINTNER, M.D.
PATRICK J. V. CORCORAN, M.D.
LOWELL H. STEEN, M.D.
LESTER H. HOYT, M.D.
MALCOLM O. SCAMAHORN, M.D.

Grievance Committee

The Grievance Committee held meetings on September 29, 1968 and April 20, 1969.

As of July 1, 1969, 18 cases were considered during the year. Six new cases were filed during the year. Most of these and old cases pending have been closed. There are six cases pending at this time.

As usual, a number of other complaints were received which were not acceptable cases for the Grievance Committee to consider. These are the type of letters which include grievances and complaints, but the person does not care to be identified or doesn't wish to follow it up after we write them. The Grievance Committee as a first step in handling legitimate complaints encourages the physicians charged to attempt a friendly discussion with the complainant. If this approach is unavailing, we persist in our efforts at local judication by asking the county medical society to attempt resolution of the problem. It is only when this effort fails or when local judication is declined that your state Grievance Committee proceeds or acts as directed by the House of Delegates. It should be noted that we are trying to handle as many of these cases locally as possible. Thorough investigation is being made into all cases which come before us.

The House of Delegates in 1967 approved the request of the Grievance Committee that legal counsel bring up to date the *Purposes, Rules and Procedure of the Board of Appeals on Patient-Physician Relations.* Dr. Philip Reed, chairman of the committee in 1967, found it necessary to resign because of moving to Florida and there has been a change in legal counsel and this matter has not been completed. Therefore, we would ask the approval to employ current legal counsel to do this work for the Grievance Committee.

EUGENE S. RIFNER, M.D., *Chairman*
EARL W. MERICLE, M.D., *Vice-Chairman*
KENNETH L. OLSON, M.D., *Secretary*
EDGAR C. STUNTZ, M.D.
RICHARD S. BLOOMER, M.D.
ROBERT G. YOUNG, M.D.
JOHN M. PARIS, M.D.
WILSON L. DALTON, M.D.
WILLIAM R. NOE, M.D.
HUGH K. THATCHER, M.D.

Student Loan Committee

The Student Loan Committee held four meetings during the past year. The committee interviewed 15 students, and loans were granted to all applicants for a total of $15,000.00.

Under the Guaranteed Loan Plan with the Indiana National Bank, which was instituted December 1, 1963, the association has on deposit with the bank $20,810.00 to guarantee loans totaling $260,000.00. As of July 31, 1969, 96 loans, totaling $83,800.00, have been granted under this plan. Thirty-eight loans have been converted to installment loans in the amount of $34,960.10. To date there have been two defaults —

one in the amount of $606.54 and the other in the amount of $1,913.00. The Indiana National Bank has been reimbursed for these two loans from the Student Loan Fund. Legal counsel of the association has been instructed to investigate the possibility of collecting these sums from the two physicians.

A report on the Loan Fund which was under association management from October, 1955, to December 31, 1963, follows:

Total loaned to 117 students	$58,458.36
Total repaid by loanees as of July 31, 1969	55,468.32
Total amount outstanding, July 31, 1969	$ 2,990.04
Of the 117 who received loans, 109 have repaid in full	
*8 are making payments	(2,990.04)
*Total due on above 8 loans still outstanding	2,990.04

The balance of $63.66 on one loan was written off because of death.

All delinquent accounts have been given to legal counsel for collection.

It is believed that the Student Loan Fund is providing an essential service to students in need of financial help and in view of the fact that there are only two defaults in our association with the Indiana National Bank this type of loan procedure should be continued.

LESTER D. BIBLER, M.D., *Chairman*
JAMES O. RITCHEY, M.D., *Vice-Chairman*
PATRICK J. V. CORCORAN, M.D.
LESTER H. HOYT, M.D.
GLENN W. IRWIN, JR., M.D.
JOE DUKES, M.D.

Medical-Legal Review Committee

I am pleased to report that the chairman of the Medical-Legal Review Committee met with the members of the Indiana State Bar Association, Medical-Legal Review Committee, on April 17, 1969.

None of the grievances presented at that meeting were against members of the medical profession. I believe the most significant business which was transacted at that meeting was that Mr. Henry E. Bradshaw who is chairman of the Indiana State Bar Association, Medical-Legal Review Committee, is contacting the California Bar Association to determine their method of operation of their Medical-Legal Review Committee which screens possible medical-legal action to determine if the case merits filing. After the information is returned to Mr. Bradshaw he will call another meeting of the combined committee so that we can attempt to work out a similar type of arrangement between the Indiana State Medical Association and the Indiana State Bar Association.

We have put together what I believe to be an interesting medical-legal symposium to be presented at the meeting of the state society, and your presence at the symposium should be beneficial to you and would also be appreciated by the members of the panel.

R. L. NEWNUM, M.D., *Chairman*
WALTER ABLE, M.D.
JOSEPH G. S. WEBER, M.D.

Future Planning

The report of the Future Planning Committee will be handled as a supplemental report.

Committee on Sports and Medicine

The newly organized Committee on Sports and Medicine met on January 26 and outlined for themselves a program of activity for the year.

A guest for this meeting was Dr. Fred V. Hein, Director of the American Medical Association's Department of Health Education. Dr. Hein advised the committee of the materials and films which are available from the AMA on the subject of sports and medicine.

The committee also discussed at length physician coverage of sports events and activities and methods of safeguarding athletes at both practice and competitive sessions.

It was agreed that regularly scheduled annual or biannual courses should be offered physicians, coaches and trainers throughout the state.

Culmination of these discussions was a special one-day postgraduate course on "Sports Medicine for Physicians" held in conjunction with the Indiana University School of Medicine. The course was scheduled for September 3, 1969.

Subjects included weight reduction and preschool conditioning for high school athletics, facts and fallacies in nutrition for the athlete, head and neck injuries, heat exhaustion and taping procedures.

Other subjects scheduled were anatomy of the knee, knee injuries and the role of the physician in pre-high school and high school athletics.

The course was acceptable for eight hours of credit by the American Academy of General Practice.

Participating in the program were members of the ISMA committee, Indiana University School of Medicine faculty, the Indianapolis Veterans Hospital, coaches, trainers, high school athletic department heads and the Commissioner of the Indiana High School Athletic Association.

A meeting of the sports physicians, athletic directors, coaches, trainers and officials has been scheduled for November 13, 1969, in Indianapolis. This will be a meeting sponsored jointly by the Sports and Medicine Committee of the Indiana State Medical Association and the Indiana High School Athletic Association. Participants in the program will be members of the Committee on Sports and Medicine; Mr. Phil Eskew, Commissioner of the High School Athletic Association; high school coaches, athletic directors and officials from the central area of Indiana.

Also prominent in the committee's discussions during the year were comments relative to medical supervision of certain conditioning practices in wrestling and to the advisability of establishing statewide conditioning standards and the concept that a single physician be empowered with the final responsibility for determining the capacity of an athlete for competition with a given team.

THOMAS A. BRADY, M.D., *Chairman*
JAMES B. WRAY, M.D., *Secretary*
JAMES H. BELT, M.D.
BRAD J. BOMBA, M.D.
LELAND G. BROWN, M.D.
ARTHUR L. MOSER, M.D.
GILBERT M. WILHELMUS, M.D.

Committee on Medicine and Religion

"Hellfire and condemnation" are not the preoccupations of this Committee on Medicine and Religion. Although there are probably some patients who think we doctors need a little condemnation given with a little hellfire for seasoning.

What this committee has been concerned with is the launching of a new program on medicine and religion to help patients by helping their doctors and their ministers work with the patient. Have you, as a doctor, had, say, an inoperable cancer in a young patient and you would like to have help breaking the news to the patient? Maybe you are fortunately on friendly terms with the patient's minister. You have an opportunity to talk it over with the minister and he, being versed in *crisis counseling*, said, "Sure! I'll see him with you!"

You were able to do your job, taking care of the disease, and you were able to delegate the part not so well trained for—the humanitarian touch.

This is a new committee of the Indiana State Medical Association. We want to get good live committees in each county. We want your county to see the two new movies available through Reverend Doctor Paul McCleave, Director, AMA Department of Medicine and Religion. These films emphasize the concept of the "physician, the clergy and the whole man."

The following topics are areas which this committee might limit our activities to save for the next year or so:

1. "Sick Sex"
2. Drugs and Other "Hang-Ups"
3. Guilt, Grace and Good Health

There are many other committees within ISMA and within communities over the state concerned with these problems. We could delineate the areas to be handled by this committee and thereby make action in these directions more effective. Would you kindly send any questions or any information that you might have to this committee regarding medicine and religion as it might affect the people of the state, particularly the people that you take care of as patients? We doctors of Indiana should be able to demonstrate that we have a humanitarian interest in our patients at heart.

BURTON E. KINTNER, M.D., *Chairman*
HELEN M. CALVIN, M.D.
JOHN C. SLAUGHTER, M.D.
JOHN E. READ, M.D.
EDWIN B. BAILEY, M.D.
RICHARD M. NAY, M.D.
LEROY D. KINZER, M.D.

Reports of Commissions

Constitution and Bylaws

The report of the Commission on Constitution and Bylaws was not completed in time for publication in *The Journal*. The report will be printed in the Handbook if the attorneys have it prepared in time; otherwise, it will be handled as a supplemental report. We hope to have the report distributed in ample time for study prior to the House of Delegates.

Legislation

Following is a report on what happened in the last legislature and those bills of importance to you.

The first is Senate Bill 33 which compels testimony of witnesses regardless of the constitutional privilege and provides immunity from prosecution for crimes exposed by the testimony. This bill became law.

The next one is the glue sniffing law. This was labeled as a misdemeanor and levies a penalty. This bill was signed into law, and as all of you know, some of the kids today go around sniffing glue and here's a real thing that you can tell them . . . we've got a law against it.

The next important one provides for a Commission for the Handicapped to develop a plan of services for multiple handicapped people, including the possible construction of a state facility. This bill was passed but it was vetoed by the Governor. This is one of the bills that ISMA supported as a package group that was put in by the State Board of Health in trying to help the handicapped throughout our state.

Senate Bill 52 authorized the State Board of Health to conduct a demonstration project involving the handicapped in order to develop state programs for the care and treatment of multiple handicapped persons. This bill didn't get to the Governor. It died in the committee.

The next was a bill that required that birth certificates of children born out of wedlock include the birthplace of the mother and father. This bill became law.

Senate Bill 57 amends the Air Pollution Control Act and establishes means to certify automobile air pollution control equipment, permit declaration of air pollution as an emergency and provide a fine of $500 per day for violations. As you know, air pollution has been one of the major concerns of the AMA, the national congress, as well as our own state organization and our state legislature.

Senate Bill 81 goes back to Dr. Rifner's time. This year all counties, cities and towns must by January 1, 1971, close all open dumps.

Senate Bill 89 is a universal bill that has been encouraged by the AMA to be passed in all states. It's the Uniform Anatomical Gift Act which authorizes gifts of all or part of a human body after death for medical and scientific purposes. This bill has been signed into law.

Senate Bill 118 eliminates the requirement that the cost of maintenance of mentally ill patients in family boarding homes shall not exceed the cost in a state hospital. This bill also became law. This takes out the possibility of a family profiting on the illness of some one member of their own family.

Senate Bill 201 permits the State Board of Health to subsidize local health departments. This is in the nature of sanitary engineers and to provide suitable staffs within the county health organization as is required. This bill we supported as one of the pluses in our efforts.

Senate Bill 215 makes it unlawful to drive under the influence of any dangerous depressant or stimulant drug in addition to habit-forming drugs as provided under the existing law. This is another one that we supported and became law.

Senate Bill 216 prohibits the issuance of a driver's license to any person determined to be a user of any dangerous, depressant or stimulant drug. This bill also became a law and was actively supported by your commission.

Senate Bill 225 requires the suspension or revocation of a driver's license and registration of any person convicted of possession, use or sale of narcotics or habit-forming drugs. This also became law and we supported it.

Senate Bill 348 revises the 1967 Meat Inspection Law to conform to the federal law and extends the mandatory date for inspection to November 15, 1970. This is one of our bills in conjunction with the State Board of Health that we supported and is another plus for us.

Concerning House Bills, the first was House Bill 1072 which provides for the implementation of Title XIX of the Social Security Act in the state of Indiana by January 1, 1970. This bill became law and as you know, your state organization did not take any stand for or against it but when we were asked, we did say that we felt that the approach to the problem was to take the minimum approach in view of the experience in many other states throughout the country. To further amplify this, Title XIX encompasses all the present health agencies such as Aid to Dependent Children, the Blind, Old Age and the Disabled. As you know, in our law, we require citizenship and also residency requirements. This would take care of that particular position to make us comply with the federal law. The second one is for children under 21 whose families do not have resources to give health assistance to those individuals under 21. This particular new concept of Title XIX in Indiana will enable us to do something about that. The anticipated cost is $270,000 for the biennium. This is part of the $14,000,000,000 total health care program for the biennium in the state.

House Bill 1151 requires doctors, hospitals, health and welfare departments and superintendents of state institutions to report handicapped persons to the State Board of Health who shall compile and analyze such reports. So, you have one more report to make to the State Board of Health. This became a law.

House Bill 1165 is the Implied Consent Law in which a person agrees when arrested for driving under the influence of intoxicants to be subjected to a breath test and authorizes the commissioner of the Bureau of Motor Vehicles to suspend his license for a period of not to exceed one year for failure or refusal to submit to a breath analysis. This bill was supported by your organization as directed by the House of Delegates and it became law.

House Bill 1240 provides that the insurance policies issued after the effective date of this act, which is April 1, 1969, shall provide for the payment of services performed by chiropractors, osteopaths and optometrists. This bill became law. As late as the day before the Governor signed the bill, he said he would not sign it, so this you can eount as a loss in our program.

House Bill 1261 permits a person under 21 who has, suspects, or has been exposed to any venereal disease, authority to give his or her consent for care and treatment of the disease. This bill became law. They can now go to a doctor and assume responsibility for their own care.

House Bill 1338, an association bill, declared that blood and blood products, as well as tissues, are a medical service rather than a sale. This died in the Judiciary Aid Committee in the Senate. They had the feeling that we were trying to legislate a lack of responsibility and we could not get the true importance of this

bill across to that particular committee so we lost. That's another minus.

House Bill 1344, another one of our bills, created a division of medical care and treatment in the Department of Correction and placed an M.D. in charge. This died in the House committee. Again, we were unable to get our point across and this is another negative against us.

House Bill 1375, a bill to provide for certification of qualified psychologists, became a law effective July 1, 1969. We supported this bill and they came to our organization long before the bill was written. We all got together and made it, what we felt, was a good bill.

House Bill 1468 amended the Medical Practice Act by deleting the limitation of a charge of $25 to take the examination and replacing it with a fee not to exceed $100. This bill passed and became law. This enabled the state board to accept the FLEX examination rather than the written examination as has been customary in the past. This is going to be a good bill that will eliminate a lot of problems, not only at the university level, but certainly in some of our Departments of Correction, for example, where we can now get people to come into the state and not have to take the examination. This is one of the very good pluses.

House Bill 1583 authorizes the podiatrist to administer and prescribe certain drugs. It does, however, prohibit the use of anti-inflammatory, systemic drugs, such as cortisone, etc.. This passed both houses and became law. With the direction of the House of Delegates, we did oppose this bill. The only thing it allows them to do is to locally treat the feet to try to prevent infection by capital application but they cannot use the steroid.

A bill for the licensing of physical therapy assistants died in the Senate committee. We did oppose it on the basis that they had so many people in the physical therapy schools now they didn't have enough professors.

House Bill 1756 created an Indiana Medical Education Authority of eleven individuals and authorized it to adopt a program to expand medical training resources, increase the number of medical graduates, to acquire a site and hire an architect for the construction of a school. This finally passed both houses but it was vetoed by the Governor.

House Bill 1775 authorizes the state Mental Health Department to establish a network of local community treatment centers for the treatment of drug abusers and this bill was also signed into law.

House Bill 1870 makes it unlawful for a person not admitted into the practice of medicine to represent himself as a physician. This bill passed the House but died in the Senate Committee on Courts and Criminal Code. We were in support of this.

House Bill 2000 prohibits children from attending school more than 30 days beyond enrollment without furnishing written proof of immunization and directs school authorities to file such proof with the State Board of Health within 60 days of enrollment. This bill was signed into law. As you know, these kids who have already been in school and come into your office and get a vaccination have created a lot of problems, so the State Board of Health has finally got this worked out so that this situation will no longer exist. We supported that bill.

Another bill authorizes the Board of Health to prescribe a form to use as written proof of TB tests for school children and directs that no child shall attend school for more than 30 days without written proof of such a test. This bill was also signed into law and we supported that.

There were many bills to create new medical schools and take over all the Marion County properties of Purdue and Indiana University and convert them into the University of Indianapolis. None of these bills were successful in becoming law, so as you can see, we had some 70 bills that were directly important to the practicing physician in this state and you see what the state organization is doing for you in the practice of medicine.

On the Washington scene it's important that you have some concept about what's going on nationally and as you know, the AMA, following the last election, has a little better report on the bills and in the White House than it did during the previous administration, and for this reason, you can anticipate that the AMA will have a forward, ongoing program. We will try not to be reactionary or put in a position of having to be reactionary, but we are hopeful that we can produce some legislation that will be helpful to the practicing physician. If it becomes necessary to become reactionary on any legislation, we certainly will do that, but we want to change our approach. Now, to review a few of the federal laws that are under consideration and some that will be of importance to you, HR 1, the first bill put in the House, has to do with the Uniform Service Academy of Health Sciences which establishes a Uniform Service Academy of Health in the District of Columbia area and provides for a 15 man Board of Regents to govern the academy. The AMA position on this has always been one of opposition. AMA feels that the same amount of money given to already established medical schools would produce far more doctors than the establishment of a single medical school for armed forces personnel.

The next one was the Health Insurance Benefit Act of 1969 which is under discussion. This bill would amend the Insurance Revenue Code to provide a new system of income tax credits for the taxpayers. This, of course, is AMA policy. Congressman Fulton has already drafted a bill and AMA has been in conference with him in attempting to get the bill drafted so that it will embody the attitudes and ideas of the AMA of giving credits for the purchase of health insurance.

Now, HR 8 is the unofficial Organ Transplantation and Technological Development Act of 1968 which authorizes the development of separate centers for separate organs. AMA opposed this on the basis of the establishment of a kidney institute, a lung institute, a liver institute —it was felt that the benefits to the kidney treatment patients, regardless of age, would be an unwarranted expansion of the Medicare program.

The next one was a reasonable allowance for physicians' services under part B of Medicare. This bill amends the Medicare program to pay for physicians' services on the basis of "reasonable allowance" rather than the "reasonable charge" basis under the present law. The secretary of HEW was determined the allowance was different in geographical areas. This bill, as you can see, disregards the physician's customary charge as a proper basis of payment and would make the basis of payment the average payment made by a nonprofit, medical, prepayment organization such as Blue Cross or Blue Shield. AMA opposes that bill totally.

Then, there were many bills on drugs. In general, AMA supports the drugs in government-sponsored programs when furnished in relation to financial needs of the patient and providing there be no restriction on the physician's free choice of drugs other than in his own professional judgment. We think that you would all agree that as long as that general policy is followed that that would be within your own ideas.

Now to mention to you a few of the bills that are in the process of being sent to your Board of Trustees and then to the House of Delegates for possible implementation in an attempt to help again the private practitioner. Here again are some of the things that the AMA is doing for you, the private practitioner in medicine, regardless of where you practice.

This first one would be a bill to amend the anti-trust laws to provide that the refusal of non-profit blood banks in the hospitals and physicians that obtain blood and blood plasma from other blood banks shall not be deemed to be acts in restraint of trade. You see, we lost this bill at the local level, but there are many implications that are involved in this in which you, the physician, could actually be sued for improper administration of blood that might have hepatitis, for example.

Next are bills to create a national advisory commission to study devices; a bill to eliminate the recertification requirements for general inpatient hospital services under title XVIII and then remove limitations of psychiatric care under titles XVIII and XIX; a bill to permit direct billing of all title XIX recipients; a bill to enable the beneficiaries under title XIX in Puerto Rico and the Virgin Islands to have a free choice of providers and services, (they haven't that now); a bill to provide the option to receive hospital care and facilities other than in VA hospitals; a bill to amend the Military Selective Service Act of 1967 as it pertains to selective service call to physicians and to provide for allocation of health personnel among the armed forces, governments and civilians.

Then the next one would be the Occupational Safety Health Act of 1969 which has to do with hazardous agents. We here in Indiana have asked some legislation in that area but we have recommended opposition to the creation and enforcement of mandatory national standards for occupational safety and health, and we have urged instead that the setting of the standards should remain within the states and that the federal government can best serve the purpose of this bill by assisting them in upgrading and enforcing their own occupational safety and health program.

The next one, is a bill that you are all familiar with. It's the new modification of the Hill-Burton proposal. The Hill-Burton, as you know, was originally a hospital construction program but today much is being said of the needs of modernization instead of construction and perhaps there has been a change of attitude that the emphasis now under Hill-Burton has impetus of modernization. The states have been spending most of their money for rehabilitation, for modernization, etc. of existing facilities primarily in urban areas and there has been less emphasis on rural areas than there has been in the past. Secretary Finch has proposed that the grant system for hospital construction be ended and replaced by a loan guaranteed program. If you read some testimonies before the house committee, there was some comment by the press that the AMA was in opposition to Secretary Finch because he was supporting the loan and we had been supporting the grant position. Well, this is not true. We do not take any position on eliminating the grant factors or eliminating the loan factors. We thought perhaps in due time that probably the grant phase could be phased out but the AMA has supported a loan guaranteed program which is in many instances, preferred over the direct grants. In loan guaranteed programs, the government acts as a guarantor and subsidizes part of the interest payment that encourages the use of the program. The federal expenditure is really a minimal one so the AMA has given testimony to this fact and has supported it. We are in accord with Secretary Finch's idea. On HR 1159 which is the Assistant Secretary of Defense for Health Affairs, the AMA has not taken any action, other than to say that they would support this but again they feel that through Secretary Laird, they would have a good ear to discuss this problem. The AMA feels that he ought to have time to review his own organization and see whether this would really be a good idea from his point of view.

As you know, Senate Bill 16 is the Adult Protection Act of 1969, better known as Preventicare. This bill establishes a multiple screening program to provide a health evaluation of all individuals, 50 years or older, who wish to participate in the program. The bill provides for the establishment and operation of regional community health protection centers and for the training of personnel to operate such centers. A provision is also made for the conduct of research related to such centers and their operation. The AMA has taken a position of opposition at this time until such time as further studies are completed concerning the use, the cost and the reliability of multiphasic screening. In other words, the AMA does not think there's been enough real study in this area to come up with a real position.

DON E. WOOD, M.D., *Chairman*
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JOSEPH D. McPIKE, M.D.
LESLIE M. BAKER, M.D.
FRED W. DIERDORF, M.D.
JOHN DAVIS, M.D.
JACK L. ALEXANDER, M.D.
MAX N. HOFFMAN, M.D.
DANIEL RAMKER, M.D.
LESTER RENBARGER, M.D.
OTIS R. BOWEN, M.D.
JACK W. HICKMAN, M.D.

Public Information

The Commission on Public Information met twice during the year to consider items of concern to the commission.

The following activities have comprised the activities of the commission for the year:

1. *Teacher Kit on Quackery*: The commission made plans to supply to school and community health workshops annually throughout the state in various regions, kits of these materials which are produced by the American Medical Association.

2. *Preceptor Program Film*: The commission encouraged the production of this film for educational purposes both for county medical societies and high school students and at the time of this report plans are being made to go into production on the film, in conjunction with the film department of the Indiana University School of Medicine in September.

3. *President's Tour*: The commission studied a plan utilized by the Illinois State Medical Society each year in which the president of the state medical association schedules appearances throughout the state to speak to such groups as Kiwanians, Rotary Clubs, Elks Clubs and other such groups on the socio-medical-political philosophies and aspects of organized medicine. Such appearances in a community would constitute a day long tour and would include radio and television appearances, as well as news conferences and interviews. The commission feels that such a plan would be an excellent public relations and public information program and encourages the adoption of such a program on an annual basis. Local plans for such a presidential visit could be coordinated through the county medical society.

4. *Film "Horizons Unlimited"*: A copy of this film was purchased by the association and loaned to Indiana Health Careers, Inc., for showing to students throughout the state at high school convocations which are organized each year by the health careers group to encourage young people to consider careers in medicine and allied health professions.

5. *Journalism Awards Program*: This program continues under the sponsorship of the Public Information Commission. There is, however, a need for more recog-

nition of the value of this public relations program by county medical societies, through which all applications for awards are channeled. These awards are made annually at the convention of ISMA.

6. *Community Service Award*: The commission at the direction of the Executive Committee instituted a community service award for physicians this year. The commission established criteria for the award and advised county medical societies of the award and urged submission of applicants. The A. H. Robins Pharmaceutical Company provides the plaque for the awardee.

7. Generally, in the area of public information, the following additional activities were conducted:

- —Arranged for and manned an exhibit on medicine as a career for a health careers conference and workshop at Indiana Central College.
- —Aided in the planning for a health exhibit at the Marshall County Fair.
- —Distributed health literature to Welcome Wagon hostesses throughout the state.
- —Provided AMA Drug Abuse Kits to physicians and teachers upon request for utilization in school lectures and teaching.
- —Provided publicity releases for various publications and newspapers throughout Indiana.
- —Provided background and resource information to newspaper feature writers and columnists on such matters as venereal diseases, smoking, drug abuse, sex, and statistics, including physician population in Indiana, etc.

In conclusion, the commission would like to reemphasize its role as the commission through which other commissions should direct matters which would have public information import. With this in view the commission notes with a great deal of interest two specific programs which have great public information potential, specifically, the developing activity of the Commission on Emergency Medical Services and its cooperative emergency sign program with the State Highway Department and the three day health conference for high school students presently being planned by the Board of Trustees for April 9, 1970. Such programming is the essence of good public relations for ISMA.

WILLIAM B. CHALLMAN, M.D., *Chairman*
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REEVE PEARE, M.D.
FRED DAHLING, M.D.
VICTOR JOHNSON, M.D.
DICK J. STEELE, M.D.
TOM S. SHIELDS, M.D.
ROBERT P. SCOTT, M.D.
J. F. HINCHMAN, M.D.
EDWARD J. DIEROLF, M.D.
DONALD K. WINTER, M.D.
MICHAEL J. MASTRANGELO, M.D.
D. D. SWIHART, M.D.
ANDREW C. OFFUTT, M.D., (advisory member)

Governmental Medical Services

The commission has considered many matters during the past year and many of them have been discussed.

We have:

1. Reviewed many of the unusual and outstanding CHAMPUS claims (old Medicare and dependent's care.) Two or three members of the commission have reviewed these claims.

2. We are still in strong support of physicians being placed on the State of Indiana Correction Board. (We feel that a physician is needed to help advise the medical facilities of our prison, penitentiary and other correctional institutions.)

3. There has been discussion about a published Rule Book on Extended Care in Medicare. This was to have been presented to physicians but it is not in appearance at this date.

4. The Indiana Regional Medical Program is now in operation. Reports have been made that grants of over one and one half million dollars for the year 1969 were allotted to projects in the area of stroke, coronary care, cancer, multiphasic health screening and community health center. (Recently the Coronary Care Unit of Marion County General Hospital has been linked by telephone to a nearby county hospital. In this manner a cardiologist interprets a patient's EKG often and as quickly as is needed in critical cases.)

The Indiana Regional Medical Program is coordinated by Robert B. Stonehill, M.D.

The commission urges physicians to make their local needs known to the Indiana Regional Medical Program.

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RAMON B. DUBOIS, M.D., *Secretary*
COLA K. NEWSOME, M.D.
ROBERT D. ROBINSON, M.D.
FRANCIS H. GOOTEE, M.D.
HERMAN ECHSNER, M.D.

Public Health

The Commission on Public Health met four times during the year.

At its initial meeting the commission visualized its role as an investigative one with the objective of keeping the association informed and exercising influences upon appropriate legislation, institutions, associations, other bodies, and the membership for the betterment of public health.

Considerable discussion during the year was given to the topics of driver examinations and medical examinations for the elderly, reporting by physicians of physical impediments relative to licensing, drug administration and/or abuse, and the use of alcohol combined with driving.

It was felt that since all of these areas are involved in licensing of drivers, that law enforcement representatives should be consulted.

As a result the commission invited Mr. Albert E. Huber, director of the Indiana Traffic Safety Council and Dr. Robert Yoho, Indiana State Board of Health, to participate in discussions.

Dr. Yoho was invited because of his involvement in emergency medical services planning for Indiana and the implications such planning have in the area of driver education, uniform traffic signs, the implied consent law and other areas which are inter-related in Indiana's total traffic problem.

Mr. Huber pointed out several problem areas in the area of traffic safety, licensure and enforcement including: 1) the lack of an agreement among the medical profession on procedures in disqualifying a person for renewal of license; 2) breakdown in effectiveness of courts due, in part, to political patronage system; 3) police officers compelled to testify during off duty hours, for which they receive no pay and are often unavailable.

As a result of these discussions it was moved by the commission to recommend to the Board of Trustees that ISMA membership become more directly involved in the work of the Indiana Traffic Safety Council; to reactivate the Committee on Medical Aspects of Driver Licensure and

to recommend further to the Board of Trustees that ISMA assist the Indiana Traffic Safety Council with at least a token financial contribution.

The commission also moved that Dr. Yoho's report be presented to the Board of Trustees of the association prior to submission to the House of Delegates.

During the year the commission also went on record as recognizing that a drug abuse problem does exist in Indiana. The commission further urged county medical societies to establish study groups on drug abuse and that these study groups coordinate and cooperate with local law enforcement agencies and educational systems in order that more effective programs be formulated for solving this problem.

To substantiate the expression of the commission, Mr. Willis A. Roose, Chief, Drug Section, Indiana State Board of Health, met with the commission and revealed factual data and information on the problem in Indiana.

Mr. Roose advised the commission that by state statute, schools are required to offer drug education to all students in grades four through eight, and it is further mandatory that all schools provide drug education courses in grades nine through twelve. The courses offered in the latter grades are elective.

The commission went on record urging that a definite effort be made by ISMA to advise local medical societies of these facts; that local societies encourage local school superintendents to implement this law, effectively, and urged that local medical societies further offer physician participation in such programs.

The commission also reviewed the law regarding the testing of all teaching personnel, and called to the attention of the Board of Trustees the existence of the law regarding tuberculin testing and chest x-rays with the recommendation that the law be distributed to all physicians in Indiana urging them to follow up all positive tests and chest x-rays.

The commission also considered the matter of reporting by private and other laboratories on venereal disease tests and endorsed the proposal that legislation be enacted by the state of Indiana requiring such reporting.

The commission further went on record as supporting the bill in the 1969 state legislature which would serve to strengthen local health departments through financial assistance.

Sex education in the Indiana public school system was given lengthy consideration by the commission. Harold Negley, representing Superintendent Wells of the State Department of Public Instruction, was invited to attend a session of the commission to enlighten the commission on current sex instruction in schools. Also present for this meeting was Dr. Robert Yoho, Indiana State Board of Health, through whose division such education is coordinated in Indiana.

As a result of these in-depth discussions and extensive research in the area by the chairman of the commission, the commission is presenting to the House of Delegates, the following report, entitled "Sex Education, Family Planning and the Federal Government" as a part of the report of the commission, and is also submitting to the House a resolution on sex education in the Indiana school system.

ROY L. FULTZ, M.D., *Chairman*
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EARLE U. ROBINSON, JR., M.D.

SIECUS, SEX EDUCATION, FAMILY PLANNING, AND THE FEDERAL GOVERNMENT

In the June 16, 1969 issue of *The Indianapolis Star*, p. 18, there appeared an article by Russell Kirk under the headline, "Teaching About Sex: A Burning Issue." The same article appeared on p. 10 of the June 28, 1969 issue of *Human Events* under the title, "Sex Education in Schools Becomes a Nationwide Issue." This to me was an interesting article. I was extremely gratified to learn of his emphasis on retaining religious and moral concepts and parent involvement in any instructional courses concerning human reproduction. I was even more gratified to learn that the California Board of Education had declared that "sex education" materials from SIECUS (Sex Information and Education Council of the U.S.) should be eliminated from public schools and that Mr. Kirk concurs with this declaration. Two paragraphs later, however, Mr. Kirk's statements become very confusing and disturbing when he writes,

> "In spite of this (SIECUS) organization's imposing name it has no connection *whatever* with the Federal government, *nor* any subsidy from public funds. For the most part, SIECUS is an offshoot of a little eccentric group called the American Humanist Association . . . ."

My confusion is because I assumed that a writer like Mr. Kirk with the reputation of being a political conservative would have the knowledge to avoid such ambiguity. My being disturbed is due to the fact that I had always felt that writers of the caliber of Mr. Kirk would adequately research their published works in order that their readers always receive the full truth.

Mr. Kirk is not alone in his inadvertant (I hope) misinformation. On the editorial page of *The Indianapolis News* July 10, 1969, the column of Robert S. Allen and John A. Goldsmith refers to SIECUS as "independent" and "non-government." Their column begins by saying:

> "Some members of the House and Senate are being fervently urged to act, but it looks as if Congress will steer carefully clear of the burgeoning public controversy over sex education in schools."

And I would predict that members of Congress would be well advised to "steer carefully clear" of the "controversy over sex education in schools" if their knowledge of the relationship between SIECUS, government, and sex education in the schools is no more complete or accurate than that displayed by columnists Kirk, Allen and Goldsmith. I would further predict that members of the House and Senate would be even better advised to familiarize themselves with the legislation already in effect (and for which many of them voted) that provides for establishment of programs of sex education in our schools.

In order to keep SIECUS in proper perspective, I submit that: 1) SIECUS *does* have connection with the Federal government; 2) SIECUS *does* have connection with subsidy from public funds; 3) SIECUS itself is quite small in terms of numbers of members; but its influence and ramifications seem to be out of proportion to its numbers; 95 is the total aggregate number of the persons who have and/or are serving on the board of directors (this number includes the eight currently listed administrative staff members); and according to the current *SIECUS General Information pamphlet*, "In every sense of the word the directors *are* (my emphasis) SIECUS."; and 4) if The American Humanist Association is the predecessor of SIECUS as implied by Mr. Kirk, its membership numbers 6,000 as listed on p. 476 of the 1969 *World Almanac*; therefore, I believe this would remove it from the category of "little."

The remainder of this article will pri-

marily involve further elaboration on some of the preceding enumcrated points. As stated in Mr. Kirk's article,

". . .SIECUS tries to impart a 'new morality' that would be anathema to the great majority of parents and responsible citizens in any community."

With this I heartily agree and further suggest that evidence available points strongly toward an effort by SIECUS members to change attitudes of the professions and the public in general. The same emphasis on "changing attitudes" is made by administrative personnel in the governmental departments with which SIECUS members have connection that is demonstrable.

That SIECUS has a connection with the Federal government can be shown simply by examining the membership roster of the board of directors of SIECUS which is listed in each *SIECUS Newsletter*. Other sources which show some of these connections are publications from the U.S. Government Printing Office that have been prepared for various departments of government. Some of these relationships are evident in the listing below:

Mary I. Bunting, Ph.D., president of Radcliffe College, in the 1966 *SIECUS Newsletter* is listed as a member of the board of directors of SIECUS. The U.S. Government Organization Manual 1966-67 on p. 481 lists her as a member of the National Science Board of the National Science Foundation. On p. 639 of the March 1969 *Congressional Directory* Dr. Bunting continues to be listed the same.

Mary S. Calderone, M.D., executive director of SIECUS, serves as an advisor to the staff of the President's Committee on Population and Family Planning—p. 7, *Report of the President's Committee on Population and Family Planning*, November 1968, and released by U.S. Department of Health, Education and Welfare. This is also stated by Calderone in the *SIECUS Annual Report* 1967-68. *Catherine S. Chilman*, Ph.D., in the June 1968 *SIECUS Newsletter* is listed as a member of the board and as Chief, Research Utilization and Development Branch, Office of the Commissioner, Welfare Administration, U.S. Dept. HEW.

Augusto Esquibel, M.D., is listed in the February 1969 *SIECUS Newsletter* as a member of its board and as Special Assistant to the Director for International Activities, National Institute of Mental Health (NIMH). NIMH is a subdivision of the U.S. Dept. of HEW (p. 355, *U.S. Government Organization Manual* 1968-69).

Elizabeth D. Koontz in the June 1968 *SIECUS Newsletter* is listed as a member of the board of directors and as President, National Education Association. On p. 554 of the March 1969 *Congressional Directory* she is listed as Director, Women's Bureau, U.S. Dept. of Labor.

E. James Lieberman, M.D., psychiatrist, in the June 1968 *SIECUS Newsletter* is listed as a board member and as Chief, Center for Child and Family Mental Health, National Institute of Mental Health, a subdivision of the U.S. Dept. of HEW. The March 1969 *Congressional Directory* on p. 569 lists Dr. Lieberman as Associate Director for Audio-visual-Telecommunications, National Library of Medicine, National Institute of Health (NIH). NIH is also a subdivision of the Dept. of HEW—(*U. S. Government Organization Manual* 1968-69).

William G. Saltonstall is listed in the *SIECUS Newsletter*, June 1968 and February, 1969, as a member of the board of SIECUS. In addition the 1968 newsletters list him as an affiliate of the Rodman Job Corps Center, New Bedford, Mass. On p. 63, *U.S. Government Organization Manual*, 1968-69, it is explained that Job Corps Centers are under supervision of the Office of Economic Opportunity, a Federal agency. The February 1969 *SIECUS Newsletter* also lists him as Curator, Alfred North Whitehead Fellowships, Harvard University.

Preston Valien, Ph.D., in 1965 *SIECUS Newsletters* is listed as a member of the board of directors and as Chief of Program Analysis Branch, Division of Graduate Academic Facilities, Office of Education. The March 1969 *Congressional Directory*, p. 570, shows that Valien's title now is Associate Commissioner for the Bureau of Higher Education, Office of Education. The latter is a subdivision of the U. S. Dept. of HEW.

Bennetta B. Washington, Ph.D., in the *SIECUS Newsletter* of 1968 and February, 1969, is listed as Director, Women's Centers Job Corps, Washington, D. C. As previously noted, any Job Corps is a division of The Office of Economic Opportunity.

Please note that all the above named persons are or have been recently *directly* connected with some major department of government; all are now or have been members of the board of directors of SIECUS. The *SIECUS General Information* folder for 1968-69 states: "In every sense of the word the directors are SIECUS." This folder points out further that, "ALL SIECUS Study Guides are subject to review and acceptance by the *entire* (my emphasis) Board of Directors." Dr. Calderone, executive director of SIECUS, in the August 1968 issue of *Medical Aspects of Human Sexuality* states on p. 40, "THE MEMBERS OF THE BOARD SPEAK FOR SIECUS as a group . . . ." In the Summer, 1965, *SIECUS Newsletter* Dr. Calderone writes, "The SIECUS Board and Executive Committee have met often and actively, and have assumed full responsibility for programs and policies."

In what has been presented thus far we see involvement of the following departments with SIECUS: 1) Population and Family Planning (HEW); 2) National Institute of Mental Health, Division of International Activities (HEW); 3) Women's Bureau (U.S. Dept. of Labor); 4) Child and Family Mental Health (HEW); 5) National Institute of Health, Library of Medicine (HEW); 6) Job Corps (OEO); and the Office of Education (HEW). This is only a partial listing of the ramifications. My *Funk and Wagnalls Dictionary* defines *subsidy* as "pecuniary aid *directly granted by government* to an individual or private commercial enterprise deemed beneficial to the public." *Fund* is defined as "a sum of money or its equivalent reserved for a specific purpose; or money readily available." *Public* refers to "pertaining to, or affecting the people at large or the community."

Public funds, therefore, may be sums of money reserved for a specific purpose affecting the people at large. Each year the President of the United States presents his budget message to Congress in which is included the cost of operation of various departments of government. The Department of HEW, the OEO, and the Department of Labor (including their respective employees) are considered in that budget. The people that I named above who are listed as governmental departmental officials, it seems to me, are receiving public funds, since our tax dollars provide the cash for the Federal budget. They are now or have been in the recent past, members of the board of directors of SIECUS.

John Money, Ph.D., Associate Professor of Medical Psychology and Pediatrics, Johns Hopkins University, is listed in SIECUS newsletters of 1967 and 1968 as a member of the board of directors of SIECUS. On p. 172, Part 1, *Public Health Service Grants and Awards Fiscal Year* 1967 *Funds* there is listed a NIMH Grant No. RO1HD 0032511 to *John Money* of Johns Hopkins University in the amount of $31,775. The project title for which this grant was made is listed as,

"Longitudinal and related psychohormonal studies." In the same U. S. Government publication other past or current SIECUS board members who received Federal funds are as follows:

p. 209 *John Rock*
Grant No. RO1HD 00614-0451 $ 1,450.
p. 231 *Frederick J. Margolis*
Grant No. RO1DE 01353-07 29,530.
p. 407 *L. Mastroianni, Jr.*
Grant No. RO6FR 00340-01 131,172.
L. Mastroianni, Jr.
Grant No. RO1HD 01810-02S1 20,957.
L. Mastroianni, Jr.
Grant No. RO1HD 01810-03 54,092.

In 1965 there was copyrighted by The Institute of Sex Research, Inc., which is located at Indiana University, Bloomington, Indiana, a book entitled *Sex Offenders*. The publisher was Harper and Row. The authors were given as Paul Gebhard, John Gagnon, Wardell Pomeroy, and Cornelia Christenson. The Fall 1965 issue of the *SIECUS Newsletter* lists *Wardell Pomeroy* and *Cornelia Christenson* as members of the board of directors of SIECUS. *John Gagnon* is listed in the Winter 1967 *SIECUS Newsletter* as a board member. On page vii of the book *Sex Offenders*, the following acknowledgement is made:

> "The salaries of the individuals participating in the years of time-consuming analysis and writing have been covered by grant monies from the National Institute of Mental Health, U. S. Public Health Service, Grant No. MH 1633."

NIMH and USPHS are both subdivisions of the Dept. of HEW. I am reminded again that SIECUS' own information folder states, "In every sense of the word the directors *are* SIECUS."

The 1967 SIECUS newsletters list *Lester Kirkendall*, Ph.D., as a member of the board of directors. On p. 140 of *Children*, July-August 1967, published by the Children's Bureau, U. S. Dept. of HEW in an article entitled, "*Starting a Sex Education Program*," the authors, *Lester A. Kirkendall* and *Helen M. Cox* have the following statement:

> "The Office of Education makes grants to support programs to prepare teachers for sex education programs and to educational institutions and community agencies to start or to improve programs in family life education and sex education, and last year helped SIECUS hold a national meeting."

The Office of Education is a subdivision of the Department of HEW, a Federal agency.

SIECUS and SIECUS board members not only concern themselves with domestic programs. *SIECUS General Information* pamphlet 1968-69 states the following:

> "A Department of International Services is in the process of formation, and a Department for Inter-cultural Services is anticipated."

In the *SIECUS Annual Report* 1967-68, its executive director, Dr. Calderone, states,

> "As one of the member agencies of the American Association for World Health, we shall be privileged to help host WHO's (World Health Organization, a health agency of the United Nations) 21st World Health Assembly in Boston in 1969."

Department of State Publication 8399 released October 1968 entitled, "*U. S. Participation in the UN: Report by the President to the Congress for the year* 1967" has several interesting items concerning WHO and family planning. On p. 103 under the heading, "Population Activities," it is stated that WHO has been a leader for several years in the study of population dynamics and further,

> ". . .WHO conducted in-service training for its staff in the fields of population dynamics, the scientific aspects of fertility regulation, and family planning methods."

On page 125 under the heading, "Role of UNICEF (UN Children's Fund) in Family Planning", is the following:

> "Upon request UNICEF will now assist countries whenever family planning is a part of maternal and child health services. WHO will review and recommend proposals for assistance within this context. Thus UNICEF has now adopted the policy of aid in family planning."

On the preceding page (124) we note the following:

> "In the light of the Board's (UNICEF executive board), approval of directing aid to high priority areas; it was not surprising that it *did not* approve expanding UNICEF operations into two new areas—the control of helminth (worm) infestation in children and the control and treatment of dental disease."

Of additional significance and interest is the financial situation of UNICEF as stated on p. 126 of the previously named State Department publication:

> "The continuing voluntary support of the American public is reflected by the size of the annual check turned over to UNICEF by the U. S. Committee. In 1967 this amounted to about $5.5 million, the proceeds from the Halloween Trick or Treat collection and from the sales of UNICEF greeting cards."

Further evidence of international involvement in family planning is obtainable from Report No. 10, Fall 1968 of the *Victor-Bostrum Fund* for the *International Planned Parenthood Federation*. This fund was, according to the 31-page booklet established to assist the movement for world population control. On p. 3 it will be noted that the fund will make at least $1.5 million available to the International Planned Parenthood Federation in 1969 and again in 1970.

> . . ."the Population Fund in Trust. . . will be financing an increased UN staff in this field."

We are further told here that the President of the World Bank, *Robert S. McNamara*, had recently announced that the Bank would make available information and finance family planning facilities of various countries. The report also stated,

> "This year the Congress, which last December had earmarked $35 million of AID (Agency for International Development) funds exclusively for population and family planning, increased the earmarked funds for 1969 to $50 million."

In this same Report No. 10 beginning on p. 16 we read what seems to be loosely referred to as a "debate" between two American "scientists," *Dr. Kingsley Davis*, Professor of Sociology, Director of International Population and Urban Research, University of California at Berkeley and *William McElroy*, Chairman, Department of Biology, Johns Hopkins University and President, American Institute of Biological Sciences. The debate is, "Will Family Planning Solve the Population Problem?" This debate, of course, concerns itself with world population control. In reality both men seem to be concerning themselves more with controlling the world's population than with population control of the world.

Dr. Davis in his discussion makes the point thusly,

> ". . .with traditional morality sponsoring familism, and with prosperity and group power viewed as functions of population growth, suggestions of effective anti-natalist policies evoke ridicule, outrage, or worse."

He points out that *indirect* measures would be thought of first; that is,

> "measures that leave people free to make their own reproductive decisions."
> ". . . one hopes that compulsory measures will not become necessary. It can be argued that over reproduction . . .that is the bearing of more than four children. . . is a worse crime than most and should be outlawed."
> ". . .The *sine quo non* of a population policy is that people be induced to curb their reproduction to the extent neces-

sary for the collective interest."

The remarks of Dr. McElroy offer very little that is basically different from a collectivist standpoint:

". . .one of the first things that could be initiated immediately is alternation of the abortion laws state by state or even nationally so as to liberalize and promote free abortions."

"there have been a number of interesting incentive suggestions that might be made part of a national policy which would encourage a reduction in the size of the family group. In a positive way, the Federal government, for example, could pay a fee to a couple if they delayed their marriage beyond a given age. For example, if they did not marry until they were 24, they would receive a $500 fee from the government: if they waited until they were 30, they might even get a $4,000 or $5,000 fee. In this way one would tend to reduce family size."

Keep in mind that the above quotes were from a report of a fund-raising arm of Planned Parenthood-World Population (formerly Planned Parenthood Federation of America, Inc.), the U.S. member of International Planned Parenthood Federation. Listed as a council member of Planned Parenthood-World Population is, *John Rock, M.D.*, former SIECUS board member. *Mary S. Calderone*, M.D., executive director of SIECUS, was for 11 years (her statement) Medical Director of Planned Parenthood-World Population. Part 3 of *Population Crisis*, a report of the Senate Committee on Government Operations dated Feb. 1, 1968 on pp. 529, 530, and 531 lists some of the chief recipients of funds from the Agency for International Development (AID). Among those receiving millions of dollars in 1968 was the *International Planned Parenthood Federation*. AID is a Federal agency.

The SIECUS Organization

Most of the material to follow has been obtained from publications of the organization itself, chiefly pamphlets and newsletters.

The organization, SIECUS, was formed in April 1964 and its first newsletter, Vol. No. 1, is dated February, 1965. According to its general information pamphlet "printed 1968-69", its board of directors consists of 50 people each serving three year terms. The executive director seems to be permanent and is *Mary S. Calderone*, M.D. Each director serves voluntarily and without pay, as an individual, "not as representatives of their organizations or institutions." Under this shelter then, they are free to express their views and recommendations in the name of SIECUS while being on the payroll of some institution, usually educational, or a government subsidy or agency. However, the booklet states, "*In every sense of the word the directors are SIECUS*", and that, "ALL SIECUS Study Guides are subject to review and *acceptance* by the *entire* SIECUS board of directors." (emphasis is mine).

The booklet further states,

"Its (SIECUS') especially prepared study guides on many difficult subjects such as homosexuality and masturbation *carry the authority of the entire SIECUS board of directors* and have enjoyed wide distribution." (emphasis mine).

The Summer 1965 *SIECUS Newsletter* states:

"The SIECUS Board and Executive Committe have met often and actively and have assumed full responsibility for programs and policy."

The membership of the board is an impressive array of professionals and includes educators, psychiatrists, pediatricians, gynecologists, sociologists, clergy, publishers, marriage counselors, and lawyers. By SIECUS' own count "19 are Ph.D's and 11 are M.D.'s." In the August 1968 issue of *Medical Aspects of Human Sexuality* Dr. Calderone states,

"The six of us who formed SIECUS in 1964 were an educator in public health, a sociologist, a Protestant clergyman, a lawyer, a family life educator, and myself. . . .SIECUS was formed in the pattern usual for voluntary health organizations, with a board to direct its programs and set policy and an executive director and supporting staff to carry them out."

Because of the impressive backgrounds, positions, and titles of SIECUS board members, their utterances are more apt to be received by the average American as the ultimate authority in sex education, especially when appearing under the banner of the Sex Information and Education Council of the U. S., Inc. Attention by members of the organization seems to focus on "changing attitudes" of individuals and society. Their stated aims and purposes in their general information folder seem to be multiple but connote preoccupation with sex. It states that the SIECUS purpose is "To establish man's sexuality as a health entity." This seems to be the chief SIECUS slogan and usually appears on the front of every newsletter and somewhere on most SIECUS materials. This slogan deserves careful analysis.

Funk & Wagnalls College Dictionary defines *sexuality* as: "1) the state of being distinguished by sex; 2) preoccupation with sex; and 3) possession of sexual power." The same source defines *entity* as: "1) something existing objectively or in the mind and 2) existence as opposed to non-existence; being."

Which combination of those definitions does SIECUS utilize in providing meaning to its slogan? An examination of further stated purposes and aims in the general information pamphlet might be helpful. Consider the following aims and purposes as expressed by SIECUS:

". . .to give leadership to professionals and to society, to the end that human beings may be aided towards responsible use of the sexual faculty and towards assimilation of sex into their individual life patterns as a creative and re-creative force."

". . . Its (SIECUS) primary aim is to open the doors to dialogue about human sexuality: What it is to be a man or a woman in today's society."

"The major purpose of SIECUS is to promote responsible sex relations. This involves the relationships between male and female (my question—why not man and wife?) in all aspects of human behavior. . . ."

". . .Sex education does not attempt as its major goal to decrease VD or out-of-wedlock pregnancies."

We would expect the organization SIECUS by its very name to focus attention on the subject of sex; however, the intensity and zeal of its executive director and some of its staff and board members would suggest that their use of "sexuality" conforms to the dictionary definition of "preoccupation with sex." That their intent is to change *attitudes* of the average citizen and especially youth through sex education in the schools becomes suggestive on examining some of the statements of SIECUS personnel. Some of these people in their utterances shun the moral concepts of our Judeo-Christian culture as they relate to sex education.

It is of significance, I think, that there seems to be in some of their suggestions and recommendations the connotation of their desire or intent to change the attitudes of professional people and community leaders toward sex and sex education. These professional people and community leaders with changed attitudes would then be expected to help change attitudes of others in order to initiate or propagate sex education programs in school systems, especially those programs outlined by the SIECUS oriented "advisors." If the professions and community leaders choose not to permit their attitudes to be changed their silence on the matter is welcomed; however, any hint of opposition to the cur-

rent SIECUS thrust by use of logic or exposure to truth is apt to bring forth a tirade of vilification that the unsuspecting public must accept with no ultimate choice but to label that person who opposes the SIECUS brand of sex education a "reactionary", an "ultra-rightist," or a part of a "small vocal minority."

Let's examine some of the ideas expressed by SIECUS personnel. Following are a few choice remarks made by *Mary S. Calderone*, M.D. in October, 1963 in San Francisco, California, where she delivered an address to an audience of the Tenth Annual Meeting of the Academy of Psychosomatic Medicine from which the following remarks are excerpted:

"It is in the sweep of these times that sexual freedom is here to stay. The word *freedom*, is not really applicable, however, implying as it does some sort of orderly sense of *responsibility*."

By way of recommendations she stated:

"I believe we owe our young people and ourselves the following:

"1. Full recognition of man's sexuality as an important health entity, a most vital faculty, no longer to be downgraded but to be dignified by openness, respect, scientific research, understanding and protection. . . .

"2. Full knowledge, not only about human reproduction, but about human sexuality as a health entity. *In the younger years* the reproductive function should be fully taught and explained, and adolescents should receive full information on *sexual functions and attitudes* from teachers skilled in this vital mission. . . .

"3. Full guidance for each individual for the constructive development and integration into his total life pattern of his own sexual potential. It isn't just a matter of teaching facts, we *must teach attitudes*. . . .

"4. Full separation, in our research and our teaching, of the reproductive and sexual functions of sex. We are approaching this concept in the developing science of the regulation of fertility. But we will have to go much farther: with rapidly emerging recognition that the average family from here on in *will have to limit itself to two children*, and with the marriage age as low as it is, we are faced with an infinite number of marriages in the world in which the reproductive function will have to be controlled while one or both of the partners may still be in the early twenties.

"In conclusion, I would submit to you that the day of click-clicking the tongue and shaking the head is or should be long, long past, as is the day of control by guilt, fear or by such words as 'duty, sacredness, ethical, ideals,' which today hold little meaningfulness for many young people. . . ."

Dr. Calderone then mentions briefly a program toward developing her ideas of man's sexuality:

". . .It would take purely and solely as its sphere of interest that area of man's life that is distinguished by the greatest lack of knowledge and the most lurid distortions since the era when medieval mapmakers drew pictures of the world as they imagined it: his own sexuality. It would serve as clearing house, sounding board, *interpreter* and *leader* for sex information and education —*for the professions* and for the *general public*. . . .

"Meanwhile we of the small group I mentioned shall want to look to such people as yourselves for the kind of understanding and support that will allow us to develop a meaningful and dynamic program as rapidly as possible."

In the 1967-68 *SIECUS Annual Report* Dr. Calderone stated:

"As an information and education agency, SIECUS has directed its efforts to three main groups: *professional* and *community* organizations and the *academic* community."

In this same report she boasts of the extent of the areas of influence of SIECUS:

"As one of the member agencies of the *American Association for World Health*, we shall be privileged to help host *WHO's* 21st *World Health Assembly* in Boston in 1969.

"There is SIECUS board representation on the Task Force assigned to plan the Fifth National Convention of the *American College Health Assoc.* in 1970. A board member represents SIECUS on the council of *National Organizations for Children and Youth* . . . has representation on the *American Academy of Obstetricians and Gynecologists*' Liaison Committee on Family Life Education . . . . I am continuing to represent SIECUS with the Commission on Marriage and Family of the *National Council of Churches*, and as an advisor for one of the panels of the *President's Committee on Population and Family Planning*. . . ."

In the August, 1968 issue of *Medical Aspects of Human Sexuality*, a monthly medical journal, Dr. Calderone is interviewed by *Dr. Harold Lief*. We are told that Dr. Calderone is executive director of SIECUS; but we are not told that Dr. Lief at that time was a vice-president of SIECUS. Dr. Lief became president of SIECUS in January 1969. Following are some statements made by Dr. Calderone in this interview: (emphasis by *italics* is mine).

"SIECUS' role with the general public is as a voluntary health organization, educating about sex *attitudes* and behavior. . . .

"One contribution that SIECUS may make to the practicing *physician* is to stimulate support by his community of his efforts *on behalf of sex education*. . . .

". . . I have published in medical journals . . . just as you have done in the *Journal of the American Medical Association*. . . . In this way we *sensitize physicians*, their *organizations*, as well as the *community*, to what we are beginning to call *education for sexuality* rather than sex education.

". . .Education for sexuality has a much broader connotation. . .it means education for the total person, the whole person, as man or as woman. . . .

". . .No community program can succeed unless it has the understanding and support of *key professional elements* in the community, of which one is certainly the *medical profession*. . . . They can help in content, but the people *to formulate the curriculum* itself are the educator who can call on physicians, psychiatrists, and sociologists as specialists. . . .

". . . Physicians are in key positions to help their patients in acceptance of *every person as a sexual person, at every age*."

The foregoing statements, it seems to me, leave little doubt as to the role the SIECUS director has designed for the physician in promoting her program of "sexuality."

In the same interview Dr. Calderone provides *her* definition of "sexuality" thusly:

"Lots of people ask, 'What do you mean by sexuality?' The dictionary definitions are very unsatisfactory, and don't give it the broad meaning that SIECUS has given it. . . . I look upon sexuality as *everything that has to do with your being a man or being a woman*. Therefore education for sexuality is *every experience you have had up to your particular stage of development as a male or as a female*. (emphasis is Dr. Calderone's).

". . .Maybe one way of putting it is that what I am really trying to do is make sexuality an affirmative way of life for people. I am trying to help people free themselves so that they can

express themselves sexually in many, many different ways. . . . It is really a way of life, for we deal with each other as the sexual people we are in all of our relationships with each other."

It is not only Calderone who seems interested in changing "attitudes." Members of the administrative staff expressed some of their own ideas in the SIECUS *Annual Report* 1967-68, *Lester Doniger*, then SIECUS president made the following comments:

"One measure of success is the now almost universal adoption of the term 'human sexuality' to denote the total concept that SIECUS has sought to establish in the public and professional press.

". . .It will be important to determine what is appropriate sex education in the earliest years, beginning with preschool and kindergarten, in relation to desired *sexual attitudes* and behavior in older years, if our goal is to be sound sex education.

". . . the adults in our culture. . . . One such service to this group might be seminars for business executives. . . . The emphasis would be on sex information and education, not on therapy, and the purpose would be to *sensitize* management to sexual problems in business life with exploration of resources for help.

"The opinion-and policy-makers, aided by the mass media in an increasingly fluid culture, have untold power to help. It must be a central task of SIECUS to try to orient these to the stake they have in better *social attitudes* about sex. . . ."

The role that members of the "helping professions" can play in *shaping the sexual attitudes* of the future is likely to be of central importance."

Frances Breed, SIECUS associate director of community services made these points:

". . .SIECUS' concept of Community Services was developed: *to sensitize the public* to the need for understanding the fundamental factors of human sexuality. . . to help the school interpret its role in sex education to the adult public; to aid the churches with supplementary material for their teaching of values relating to sexual behavior.

"Two patterns of community action . . .by SIECUS: 1. Work with community councils. . .planning major public meetings and workshops to broaden understanding of sex education; 2. Consultation over an extended period of time between the community group and SIECUS, helping to *promote local support for sex education programs*" (my emphasis).

Esther D. Schulz, Ph.D., SIECUS associate director of educational services pointed up the role of the teacher in the scheme of things in this same SIECUS report:

"The predominant thrust during 1967-68 was teacher preparation in the area of human sexuality . . . .

"*Teacher readiness* is defined as that point when the instructor is able to transmit sex information in an unbiased manner.

"Our role as consultant is to aid in interpreting content; to suggest a range of educational materials for human sexuality from which a school can make appropriate choices; to outline the theoretical background advisable for teachers. . .and such classroom dynamics as role playing and group discussion.

A future activity of great importance will be to attempt *to develop standards for evaluation* of current sex education programs in schools. . .an important adjunct to this project is assessment and *evaluation of teacher* preparation programs. *This project has already been initiated*" (my emphasis).

The *SIECUS Annual Report* 1967-68 further points out that,

"Major grant support has come from The *Commonwealth* Fund, The *Ford* Foundation, *Kimberly-Clark* Foundation, and the *Public Welfare Foundation, Inc.*"

All contributions to SIECUS are deductible for purposes of income taxes.

In the Winter 1968 *SIECUS Newsletter*, the heading of p. 11 begins:

"FUNDING FOR PROJECTS ON FAMILY LIFE AND SEX EDUCATION available and granted under specific eligibility standards by the following *ongoing programs* of the Office of Education, United States Department of Health, Education and Welfare. (Unless otherwise noted, address is Office of Education, 400 Maryland Avenue, SW, Washington, D.C. 20202)."

Nine different offices or programs are then listed, all of which are directly related to the U.S. Office of Education. In at least one instance that I know of, inquiry was sent to one of the above mentioned offices requesting information on funding of a program of sex education. Among the materials received as a result of this inquiry was a booklet entitled, "Two Articles on Family Life and Sex Education", reprinted from the July-August 1967 issue of *Children*, a magazine published six times yearly by *The Children's Bureau*, U.S. Dept. of Health, Education and Welfare. One of the articles was co-authored by a founder and board member of SIECUS, *Lester A. Kirkendall.* Even though these articles may not represent the policies of The Children's Bureau on sex education, they do reflect the ideas of those people who are working closely with those who establish policy. Following are excerpts from article No. 1, "Helping Children Grow Up Sexually", by *Eleanor Braun Luckey.* Luckey's biographical note states that she has a Ph.D. in psychology from the University of Minnesota, is 1) head of the Department of Child Development and Family Relations, University of Connecticut; 2) is a special consultant to the Children's Bureau on family life education; and 3) is on the executive committee of the National Council on Family Relations. I believe that the emphasis on changing "value systems" and "attitudes" is apparent in some of the quotes which follow that were taken from this article by Luckey

". . .programs of sex education (are) . . .sometimes called family life education, boy-girl relationships, or interpresonal development.

". . .the goals of sex education are not altogether clear. Nor is it clear just whose responsibility it is to give sex information to children and adolescents and to try to *shape the attitudes* that determine their moral values and sexual behavior.

"In any culture, what is 'normal' depends upon the practices of the majority. Many behavior patterns that are quite objectionable in our society are sanctioned in others; for example, homosexual practices, sexual relationships between children, premarital sexual promiscuity, and wife swapping and borrowing are approved forms of behavior in some societies. It is not possible to speak of what is or is not 'normal' unless we specify the society to which we refer.

"Even *in this country* alone the wide *range of sexual behavior and values* existing today *make 'the norm' impossible to define.*

"*Sexual maturity* rather than sexual normality may be a *better goal for sex education.*

"What is immoral in today's society may be moral in tomorrow's. And what is right for today's generation of young people may be wrong for a generation to come.

"One way to avoid getting hopelessly involved in dilemmas is to go . . . to a *broader concept of morality*, one based on the use of self and one's personal freedom for the benefit of others.

"Unfortunately, our culture has for

a long time treated a sexual relationship as a special and separate part of personal and social relationships rather than a normal, natural use of self in relating meaningfully to a person of the opposite sex.

". . .the real goal of any program must be to help in the total development of young people so that they will become the kind of secure persons described above.

". . .the person who works professionally with young people can take a number of steps toward furthering a program of education that will make for mature sexual behavior in our society.

"1. He can help other professional workers define their values and learn how to convey them to others. One of the most helpful tools. . .is the *sensitivity group*, sometimes called the *T-group* . . . the group is designed to encourage its members to *interact in such a way* that insight and self-understanding develop. . . .

"2. He can take part in *inservice training sessions*, workshops, and institutes that provide. . .opportunity to clarify their own *attitudes* for themselves. . . .

"3. He can focus much of his educational efforts on parents. . .the parental influence is so constant and so intense, what parents believe, what they convey, and what they know are crucial influences in the development of the child's *sexual attitudes*.

"Parents, however, often have uncertainties and fears about their own sexuality . . . .

"Thus many parents might benefit from the same kind of *sensitivity group* suggested for professional persons."

A second article in this reprint from *Children* from the Department of HEW is by *Lester A. Kirkendall*, Ph.D., founder and board member of SIECUS and Helen M. Cox. Following are excerpts from that article entitled, "Starting a Sex Education Program":

". . .any school, any community is fully warranted in saying that it is 'expanding and improving' rather than 'starting' a sex education program.

". . .We need a broader idea of sex education. . .such as that offered by the Sex Information and Education Council of the U.S. (SIECUS), an interdisciplinary organization founded in 1964 to 'establish man's sexuality as a health entity' and 'to dignify it by openness of approach, study, and scientific research.'

"*We do not favor asking parents to decide whether their children may attend a sex education program.* Such a policy implies fear and uncertainty in school authorities and brands sex education as something 'different.'

". . .*effective teachers for sex educatoin programs may come from any field;* they may be men or women, married or single, parents or childless.

"Several Federal agencies have been giving active support for some time to programs preparing young people for marriage and family living. The Public Health Service, (a division of HEW) in its regional conferences, has been urging the schools to offer sex education. The *Office of Education* makes grants to support programs to prepare teachers for sex education programs and to educational institutions and community agencies to start or to improve programs in family life education and sex education, *and last year helped SIECUS hold a national meeting*" (my emphasis).

SIECUS Newsletter, Summer 1967, concerns itself with "teacher preparation" and is written by Esther D. Schulz, Ph. D., Associate Director for Educational Services, SIECUS and *Sally R. Williams*, R.N., M.A., board member of SIECUS. Some of their comments follow:

"Because of the importance of objective classroom discussion about human sexuality, some school districts, on a local basis, and college workshops are including *sensitivity training* as part of teacher preparation. The extent to which teachers can control their biases and permit unrestricted discussion will determine, to a great extent, the continued interest of students.

"The voluminous number of curricula sent to SIECUS for review and assessment shows a strong biological theme or emphasis. Also, inclusion of smoking, venereal disease, alcoholism, drug addiction, and general health practices appears in most curricula. *SIECUS believes these areas should be part of a health education or science curriculum rather than of family life and sex education*" (my emphasis).

Another publication by the Children's Bureau, U.S. Dept. of HEW is "Selected References for Social Workers on Family Planning." Inside the back cover is the following notation:

"The purpose of this publication is to provide social workers with information useful to them in developing programs for and giving services to families who will be receiving family planning services."

Two of the first three references in this bibliography were authored by *Mary Calderone*, executive director of SIECUS. The commentary on the article by Calderone entitled, "Health Education for Responsible Parenthood", states:

"Until *attitudes* catch up with our new thinking on the responsible use of sex, our programs will not meet the need. The health educator has the job of *changing these attitudes* in the clinic, in the family, and in the community."

The Roles of the Federal Government

Another area that deserves inquiry and examination is the role of the Federal government in sex education programs. Are any such programs proposed, by virtue of what legislation, under whose leadership, and by which governmental departments or agencies? The remaining material from which I quote has all been obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402. Most informative are two documents released by the Dept. of HEW in 1968: 1) *Family Planning: Nationwide Opportunities for Action* and 2) *Population and Family Planning Report of the President's Committee on Population and Family Planning.*"

In the appendix of *Family Planning* is the text of a memorandum by the Secretary of the Department of Health, Education and Welfare addressed to heads of operating agencies concerning family planning policy and is dated Jan. 31, 1968. Significant points made by the secretary are as follows:

"Family planning has been established as *a priority program* within the Department. Each operating agency will utilize its existing authorities to the maximum to promote the development of family planning services.

"Family planning programs conducted or supported by the Department shall guarantee freedom from coercion or pressure of mind or conscience.

"Finally, we must increase public and individual understanding of family life *and sex education.*

"The Deputy Assistant Secretary for Population and Family Planning in the Office of the Assistant Secretary for Health and Scientific Affairs will serve as the focal point for departmental policy and program coordination. . . will cooperate with interested public and private groups; and will issue a statement of actions required to achieve these objectives within the Department" (my emphasis).

In another memorandum on the same date addressed to the same operating agency heads we see the Family Planning Program Objectives outlined in more de-

tail by the Deputy Assistant Secretary for Population and Family Planning. Significant parts are quoted below. Emphasis by italics is mine.

". . . the objectives of family planning programs are to:

* assist parents in attaining and maintaining the family size they desire;
* improve understanding of family life and *human sexuality*.

"SERVICES: Making family planning information and services available and accessible to all in the population who desire and need them.

"TRAINING: Meeting the manpower needs. . . .

"To achieve training objectives, it is necessary:

"To encourage institutions responsible for the professional education of personnel in health, welfare and education fields to include in their curricula, when appropriate, population dynamics, *human sexuality*, fertility regulation and related subjects.

"To support training of social workers, nurses, teachers, clergy, guidance personnel and others in order to aid progress designed to develop further opportunities for *family life and sex education.*

"RESEARCH: Applied research is needed to use . . . in finding ways to promote acceptance of family planning both as a general concept and as a personal commitment.

"To achieve training objectives it is necessary:

"To encourage studies in the behavioral and social sciences of factors which affect *attitudes*. . . .

"PUBLIC EDUCATION AND UNDERSTANDING: Increasing opportunities for *sex education* and public understanding of *family life.*

"To achieve the objectives it is necessary:

"To provide *all young people* with adequate knowledge of human reproduction and information regarding modern scientific advances in the field of *contraception and its meaning* in relation to child spacing and responsible parenthood.

"To assist communities and educational institutions which wish to initiate or improve programs in *family life education* as an integral part of curriculum *from preschool to college and adult levels.*

"To promote family planning information and counseling as an integral part of the services of health and welfare agencies and to encourage the inclusion of family planning and *family life education* in the activities of *youth-serving agencies* and adult education programs.

"*To stimulate appropriate mass media* sion of family planning and *family planning.*

"To study effectiveness of communication among the various *target groups* including the consumer of family planning services."

In the introduction to the booklet, *Family Planning*, it is stated that the *major Federal agency* dealing with family planning activities is the *Department of Health, Education and Welfare;* and that it cooperates with other Federal agencies in reaching special domestic *and foreign publics.* The following recent legislation is given as the avenue through which Federal funds may be utilized in the family planning effort; Child Health Act of 1967; public welfare amendments (1967) to the Social Security Act; 1967 Partnership for Health Amendments to the Public Health Service Act; Title 19, 1965 of the Social Security Act (*Medicaid*); 1967 amendments to the *Elementary and Secondary Education Act of* 1965; and the Comprehensive Health Planning and Health Services Act of 1966. Following are a few of the Federal agencies, departments, or programs that are listed as being involved: The major one—HEW; Department of Defense; Office of Economic Opportunity; Department of Labor; Department of Agriculture; Department of State—Agency for International Development (AID); Department of the Interior; Social and Rehabilitation Service: National Institute of Health; National Institute of Mental Health; Consumer Protection and Environmental Health Service; Department of Housing and Urban Development; and the Model Cities Demonstration Programs.

In order to best demonstrate the scope, significance, and importance of this *family life-sex education-family planning* priority as expressed by this publication prepared by the Dept. of HEW, I am listing a few quotes below:

"In dollar terms, the *greatest potential source of Federal support* for voluntary organizations, as well as for private physicians who give family planning services, is the Federally aided *Medicaid* program. . . ." p. 9

". . .in a policy statement issued by the Commissioner of Education in 1966. He announced that the *Office of Education 'will support* family life education and *sex education* as an integral part of the curriculum from pre-school to college and adult levels; it will support training for teachers and health and guidance personnel at all levels of instruction. . .and it will support research and development *in all aspects* of family life education and sex education.'" p. 13-14

"One of the results of the Federal aid has been that *all state departments of public instruction now have* one or more persons who are specifically assigned to help local schools with sex education programs." p.14

"Since almost any type of grant made by the Department of Health, Education and Welfare to any type of organization for family planning activities can be used to include a public education component, those applying for such grants may wish to round out their programs by including this aspect in their plan or proposal." p. 15

". . .*Federal aid can support the production* of textbooks, popular and professional publications, films and other *materials needed for sex education* and family planning programs. Production of such materials can also be supported as an element of a broader project." p. 24

"Among the projects being supported by the National Institute of Child Health and Human Development is a study of the effects of intrauterine devices on several species of experimental animals. Studies of the systemic effects of intrauterine devices in women are also receiving support." p. 26

"Studies supported by NIMH grants include an analysis of family planning *attitudes* in a village in *India* and studies of the psychological effects of certain surgical procedures such as *vasectomy* and *therapeutic abortion.*" p. 27

The second document I mentioned previously, *Population and Family Planning*, will be considered. This 43 page booklet released through the Department of HEW is the report of the President's Committee on Population and Family Planning which was appointed by President Johnson July 16, 1968. The report was published in November, 1968.

The committee is chaired by Wilbur J. Cohen, then Secretary of HEW. On pages 6 and 7 of the report are listed the committee members, staff members, and technical advisors. Most of the members of these three groups are employees of some Federal agency; but are mostly in the Department of HEW, the Office of Economic Opportunity, or the Agency for International Development. Two committee members, two staff members, and one technical advisor were officers of the Population Council. *John D. Rockefeller III*

is co-chairman of the committee and is chairman of the Board of Trustees of the Population Council. The Population Council is a private organization, reportedly non-profit, created in 1952 and financed primarily by the *Rockefeller Foundation.*

The Ford Foundation is represented by Dr. Oscar Harkavy whose report on *Implementing Department of HEW Policy on Family Planning and Population* begins on p. 163 of Part 1 of hearings on S. 1676, a bill to reorganize the Department of HEW. Recall that it was noted previously in this article that according to Dr. Calderone, the Ford Foundation has been one of the major "funds" to contribute to *SIECUS.*

Planned Parenthood-World Population (formerly Planned Parenthood Federation) has two representatives on the president's committee: Paul H. Todd, Jr., its chief executive officer and Mr. Frederick S. Jaffe as an advisor. *Mary S. Calderone,* M.D., executive director of SIECUS, is also an advisor to the president's committee and was for 11 years a high official (Medical Director) of Planned Parenthood-World Population. *John Rock,* M.D., a former SIECUS board member, is listed as a council member of Planned Parenthood-World Population; and has been noted previously in this report to have been recipient of a direct Federal grant in 1967. PP-WP was previously discussed in relation to its fund raising arm, the *Victor-Bostrum Fund.*

The crux of this committee's report, *Population and Family Planning,* is a number of recommendations to the Federal government concerning policy and priorities. A *five-year policy plan* was outlined for the Dept. of HEW. Major recommendations exclusive of the five-year plan include the following:

1) Family planning is to assume priority status and these services should be made available to all who want them by 1973.

2) The Office of Education should provide significant assistance to appropriate education agencies in development of materials on population and family life.

3) Private organizations and the mass media should be encouraged to expand their efforts to promote public understanding of effects of population trends on family life.

4) The U.S. should increase and expand programs of international assistance in population and family planning.

5) Experienced foreign specialists should be invited to serve on advisory groups for both our domestic and international programs.

6) The Federal government should increase research grants particularly as regards contraceptive methods and programs.

7) The Federal government should establish basic support for population studies centers.

Of most ominous significance is the suggested *five-year plan* for HEW and OEO which would be based on current organizational structure. The plan would provide family planning materials in curricula of *medical* and other schools; expand project grants, formula grants, *Medicaid,* and cash assistance in family planning; a three year training program for Department of HEW personnel in family planning would be implemented. The plan would be supervised by the office of the Deputy Assistant Secretary of Population and Family Planning; and is to be reviewed, approved and/or modified by the Secretary of HEW. *Each year the five-year plan would be updated and one more year added.*

The five-year plan is summarized on p. 41 of the booklet, *Population and Family Planning;* and contains the following: (That portion of the text which is emphasized in the original is in italics).

"Although the five-year basic operating plan will be substantially changed and revised as time goes by, the plan is useful as a tactical mechanism:

"*to force *decisions* on budget, personnel, and operations in accordance with top-level DHEW policy;

"*to provide a means to check *results* against *promises;*

"*to provide a meaningful *power center* at the regional level;

"*to bring the Office of the Deputy Assistant Secretary for Population and Family Planning to bear directly on the *decision process;*

"*to provide a mechanism by which *evaluation results* can help shape program decisions.

"This outline for a basic five-year operating plan for a domestic program is presented in detail as a model suitable for other agencies."

Best we not forget that most of the recommendations of the president's committee were implemented in the document, *Family Planning,* released by HEW and containing the memorandum of the Deputy Assistant Secretary for Population and Family Planning, Katherine B. Oettinger. This memorandum was also approved by Philip R. Lee, M.D., Assistant Secretary for Health and Scientific Affairs.

The naive among us would perhaps surmise at this point that what has just been discussed regarding sex education is only an outline or a proposal for what might come to pass. Let's take another look.

Already in 1969 the U.S. Office of Education, U.S. Department of HEW, released through the U.S. Government Printing Office a publication called, "*Pacesetters Innovation, Fiscal Year* 1968." The stated purpose and use of this document is as follows:

"Pacesetters in Innovation, Fiscal Year 1968, "presents information on Projects to Advance Creativity in Education (*PACE*) approved during fiscal year 1968. The PACE program is authorized and funded under *TITLE III,* Supplementary Centers and Services, of the Elementary and Secondary Education Act of 1965.

"This volume represents a compilation of planning and *operational* grants."

On p. 69 of the *Subject Index* we note a listing of five separate projects by title, four of which are classified as operational under the heading *Sex Education.* On p. 16 of the "Project Resumes" section is a description of the operational project entitled, "T-V, A New Dimension in Health Instruction." Excerpts from that description are as follows:

"Calif., Pasadena, unified School District

"Descriptors . . . Community Involvement, Grades 1-6, Grades 7-12, Health Education, Sequential Programs, *Sex Education,* Video Tape Recordings, Alcoholism, Drug Addiction, First Aid, etc.

"A sequential program of health education, using videotaped instructional units, will be offered to all students in an urban area. . . . An understanding of mental health and *man's sexuality* and its influence will be incorporated at every grade level.

"Approximately 41,404 students, Grades 1-12, will be served."

A second operational program described on page 34 contains the following information:

"Countywide Direction for Family Life Education"

"Descriptors-Articulation (program), curriculum development, *Family Life Education,* Grades 1-6, Grades 7-12, Interagency, coordination, *sex education,* instructional materials.

"A family life and sex education program will be developed for students in an urban/suburban area. A series of articulated instructional units will be formed for Grades K-12. . . .Model programs will be developed for courses of study and will be adapted to the needs of each school. Approximately 140,790 students, Grades K-12 will be served."

A third operational project in its de-

scription beginning on p. 59 contains the following:

"Developing and Implementing a Program That Provides a Basis for Social and Emotional Growth—grades K-8.

"Descriptors: Curriculum Development, Emotional Development, Grades 1-6, Grades 7-12, Group Counseling, *Sex Education,* Social Development, Adolescents, Grouping (instructional purposes), Interdisciplinary approach, Outdoor Education, Parent School Relationship, Parent Workshops, Self Concept, Small Group Instruction.

"*Sex education will be introduced* into the K-8 curriculum for students in a rural area. Emphasis will be placed upon presenting information on human sexuality through an interdisciplinary approach. . . . *Sex information* will be systematically integrated into academic subjects in the regular curriculum. *Special learning situations* will be constructed to facilitate student development in the areas of. . .(1) achievement of sexual identity, (2) skill in the *sex-linked social roles,* and (3) capacity to have meaningful relationships with members of the opposite sex. *Social interaction* in small group situations will be stressed. Adults and children in grades K-5 will be involved in intrinsically interesting/productive activities both in the classroom and out of doors. Both a male and female adult will be present to guide the activities of the groups. Small-group counseling will be offered to sixth, seventh, and eighth grade students. . . . Approximately 698 students, Grades K-12 will be served."

Do these examples leave any doubt as to the intent of the priorities given to the *family life-sex education-family planning* programs outlined by the Department of HEW?

Summary and Conclusions

From what has been presented it seems fairly obvious that there is operational today a relatively young, relatively small "private" organization called SIECUS (Sex Information and Education Council of the U.S.) whose preoccupation is sex and whose intent seems to be the changing of attitudes of the professions and the public toward it. SIECUS' president of 1967, *Lester Doniger,* alluded to this when he stated in the *SIECUS Annual Report* 1967-68:

"One measure of success is the now almost universal adoption of the term 'human sexuality' to denote the total concept that SIECUS has sought to establish in the public and professional press."

This term we have seen repeatedly in the policy statements and programs outlined by the U.S. Department of HEW.

The members of SIECUS are professionals with impressive titles and degrees. They enjoy positions representative of authority and seem to be accepted authoritarians and experts. Most of the membership, even the M.D.'s, are aligned with what has come to be known as the "behavioral sciences" that are little understood by the average G.P. or the general public. However, I hope that most M.D.'s will see the effort being made to recruit their support for the SIECUS-type of sex education and will not fall victims to such a ruse.

The target of the programs suggested by SIECUS is our youth through the educational process and through the training or "re-training" of teachers who would teach sex education. Dr. Calderone said it in 1963 in San Francisco:

"*In the younger years* the reproductive function should be fully taught and explained, and adolescents should receive full information on sexual functions and attitudes from teachers skilled in this vital mission . . . . It [alluding to SIECUS which was not yet chartered] would serve as . . . *interpreter* and *leader* for sex information and *education* . . . for the *professions* and the *general public.*"

The Federal programs as outlined in the Department of HEW publications are then "on target" with their programs of sex education for grades K through 12; and their "teacher training" programs and sensitivity training techniques.

Youth is the most critical area of the life of any nation. My experience with most of our present youth has been that they are eager to learn and apply what they learn; and their feelings of insecurity result from looking to their peers for guidance in the form of concrete answers, and too many times being refused those answers.

Permanent guidelines of morality are as necessary to the total development of a youngster as the basic fixed formulae of physics are necessary for sending men on a round trip to the moon. To deprive youth of these guidelines in their formative years is to deprive them of sound doctrine. Our young people are deserving of the full benefits of sound doctrine in their pursuit of education and personality development. In fact, it is mandatory to our survival as a nation.

To deny youngsters in their educational process exposure to Judeo-Christian concepts of morality as they relate to sexual matters is, in my opinion, depriving them of sound doctrine. These concepts are permanent, quite simple, concise, and clear. The SIECUS purpose is stated as, "To establish man's sexuality as a health entity." To examine these phrases in terms of Judeo-Christian morality makes this slogan seem very ridiculous: man's sexuality *is* established in Genesis 1:27 . . . "So God created man in his own image, in the image of God created he him; *male and female* created he them."; "as a health entity" is confirmed in Genesis 2:18 . . . "And the Lord God said, *It is not good that the man should be alone;* I will make him an help meet for him."; and the moral aspect is added further in Genesis 2:24, 25 . . . "Therefore shall a man leave his father and his mother, and shall cleave unto *his wife;* and they shall be one flesh. And they were both naked, the *man and his wife,* and were not ashamed."

Mr. Average American is being constantly bombarded with the Pavlovian stimuli that we are living in "changing times" in an "affluent", "progressive" society; and if we as individuals are to survive comfortably (physically and emotionally), then we must "adjust" to these changes by a "reassessment" of our "value system." If Mr. American doesn't do this, he is led to believe, he will drift out of the "mainstream" and the most practical thing for him to do is to change his "attitudes" toward tradition; because he is further led to believe that standards are different now in this new "great society" and "technological age" from what they were in his day of youth. Mr. American, do not be misled by this verbal garbage that the "experts" serve you! Mr. American, do not just reassess but *resume* assessing constantly; and let your *reason* not your emotions prevail. Be realistic!

The realism here is that standards have not changed; but peoples' conduct relative to standards has changed and subsequently *attitudes* toward those standards have changed.

The SIECUS people choose to omit the moral aspects of sexuality from their recommended sex education programs. This is justified according to them on the grounds that this is the responsibility of the home or the church. I maintain that youth is the responsibility of *every* adult who at any time has the opportunity to instruct him in sound doctrine. To condone a morally sterile sex education program is but to contribute to the moral decline of our nation through placing a stamp of approval on amorality for our youth. If the medical profession yields to the demands to change its "attitudes" about sex education and is persuaded by ear-tickling phrases to assist in changing

the attitudes of the general public; then it is doomed as a respected profession and would so deserve to be.

With Medicare and Medicaid the same "humanistic" carrot was dangled before the medical profession to persuade them to "go along" for the sake of "these old people"; and "after all, it was the law of the land." We are still smarting from reverberations of the warnings on that one. It is not necessary that the medical profession repeat past mistakes and surrender even more important principles. SIECUS is not the law of the land and to reject its programs and influence *in toto* is a violation of no law.

In conclusion, it might be appropriate to muse on a few thoughts from the Book of Proverbs:

"A wise man will hear, and will increase learning: and a man of understanding shall attain unto wise counsels."

"The fear of the Lord is the beginning of knowledge: but fools despise wisdom and instruction."

May the medical profession responsibly seek always to act wisely and with knowledge.

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Voluntary Health Agencies

The organizational meeting of this commission was held on November 17, 1968. Doctor Corcoran, president of ISMA, outlined the goals of this commission for the year and submitted a number of suggestions from the Board of Trustees of the works of this commission. The commission has kept these directives in mind through the entire year and practically all of the suggestions have been carried out. Where suggestions were made that cannot be carried out, those concerned have been given an explanation for the reasons.

The following commission officers were elected: Dr. Wayne Endicott, elected secretary; Dr. M. O. Scamahorn, vice chairman and Dr. Norman Booher, re-elected chairman.

Plans for the year were gone over in detail and liaison appointments to the voluntary agencies operating on the statewide program in Indiana were made. As usual, the commission assigned specific members of the commission to two or more voluntary agencies and these members were charged with the responsibility of becoming familiar with the personnel and policies of these agencies and reporting their views to the commission as a whole. Plans for the remainder of the year were made and reduced to writing.

One of the most important annual projects of this commission is to meet in January with the executives and officers of all the voluntary health agencies with statewide programs in Indiana. This meeting was held in association headquarters on January 19, 1969, and every agency was represented—in most cases by a president and the chief executive officer and in some instances by more representatives. A three hour dialogue was enjoyed between your commission and these individuals and several projects for cooperative action were outlined. One of the main suggestions of these agencies to our association is that we do more to assure the cooperation of physicians throughout the state with the voluntary health agencies. It was also suggested that the cooperative activities of the commission and the agencies should receive as much publicity to the members of the state association as possible. As a result of this recommendation, Mr. Waggener agreed to insert such information in the News Flash from time to time.

The agencies with state programs emphasized the need in their opinion for county societies to have a committee that was actively interested and alert to the work of the voluntary health agencies in their particular areas.

The elimination of duplication was brought up by members of the commission to the agencies and there was some discussion of an Indiana Voluntary Health Council. This was not consummated because of a question of possible duplication in the Comprehensive Health Planning Council.

The intense desire on the part of the voluntary agencies for the placards previously published by this association setting forth the names of the voluntary health agencies that have met the criteria of the ISMA was made evident. The agencies voted to assist in the distribution of these placards in some instances and in some areas to assume the entire responsibility of distribution.

In this joint meeting in January, the joint scientific meeting in cooperation with the Indiana Public Health Association and the Indiana Tuberculosis Association was planned and since the dean of the Indiana University School of Medicine had promised a better audience of students this year than last, it was decided to repeat the program at the medical center to acquaint medical students with the potential resources offered physicians by the voluntary health agencies.

On Wednesday, February 5, a joint committee between the voluntary health agencies and the commission met to plan a program for the April 24th Indiana Public Health Association meeting. An excellent program was planned. The speakers included Dr. G. O. Larson, past president of the association, Mr. Glenn Sample of the Farm Bureau and a member of the Comprehensive Health Planning, Dr. Mark Dyken on "A Unique Approach to a Statewide Locally Oriented Program" and Dr. Merritt Alcorn on "Implementation of the Comprehensive Health Program."

The next meeting of the commission was the attempt to present a program that had been the subject of much effort on the part of all voluntary agencies to the medical students in Indiana University Medical Center. Last year a similar program was attempted and material assembled but less than ten students appeared. For this year's program the dean of the medical school had promised a good audience—nine speakers had prepared a short address from the voluntary agencies, plus remarks from this commission. This was scheduled for 4:00 P.M., March 19, and while all of the speakers and members of this commission who were sheduled for appearances were present, less than twelve medical students attended. This was a great disappointment to all concerned and a matter for many questions.

The biggest program of the year was held on April 24 and was the joint scientific meeting of the Indiana Public Health Association and the Indiana Tuberculosis Association on April 24. The program for this meeting was outlined above. It was very successful and again proved to be most worthwhile, both from a scientific point of view and, especially, from a public relations standpoint. This meeting was preceded by a breakfast for which the medical association was host, at which time the speakers and representatives from the agencies were guests. Following the joint scientific meeting, the commission members attended a joint luncheon with the Indiana Public Health Association, followed by a business meeting occupying most of the afternoon at which routine business was transacted. The commission also had the privilege of a discussion from Dr. Lowell Steen as a liaison officer from the Board of Trustees. At this meeting, the final agencies which were recognized for the current year were determined and the list given to Mr. Kenneth Bush for publication of the placards

which were to be done and distributed in May.

At this meeting, the commission discussed plans for their joint meeting with the Council of the AMA on Voluntary Health Agencies to be held in Indianapolis, October 11 and 12, 1969. At the time of the writing of this report only projected plans can be reported. The Council of the AMA will meet the morning of October 11 at the Stouffer Inn and will be joined at 11:00 A.M. by members of the commission of the state medical association for luncheon in the Speedway Motel, after which the two groups will be addressed by Dr. Thomas A. Hanna, chief medical director of the Indianapolis Motor Speedway, following which we will have a very brief tour of the Speedway itself. At 3:30 P.M. the Council of the AMA and the commission of the association will have a joint meeting at the Stouffer Inn and at 7:00 P.M. the ISMA will be the host for dinner at Stouffer Inn for the council and their wives; the assigned staff of the AMA, the president of the AMA and other distinguished guests represented on the regional conference which will embrace 11 states to take place on Sunday, October 12. At this dinner, the members of this commission and the officers of the ISMA will also attend as assistant hosts.

The commission requests the House of Delegates to approve its activities in the past year and would recommend that a similar program be followed in the year to come with the possible exception of any cooperative program with the Indiana University School of Medicine.

The placards are in the process of distribution and it is felt that they should be continued and again this commission recommends that greater effort should be made to bring the work of this association with the voluntary health agencies to the notice of the public. It is felt that a great deal of good public relations would result and that organized medicine of this state would be given credit for an effort that is now unknown to those whose opinion we value.

The commission again cannot express strongly enough its appreciation to Mr. Kenneth Bush, a member of the staff assigned to this commission and to Miss Eleanor Chapple, both of whom have given enthusiastic assistance to the commission.

NORMAN R. BOOHER, M.D., *Chairman*
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CHARLES RUSHMORE, M.D.

Medical Economics and Insurance

The Commission on Medical Economics and Insurance for 1968-1969 is composed of Thomas J. Conway, Terre Haute, chairman; Kenneth O. Neumann, Lafayette, vice-chairman; Paul M. Inlow, Shelbyville, secretary; Charles M. Sinn, Evansville; Paul W. Holtzman, Bloomington; Edward J. Ploetner, Jasper; William Scharbrough, Ewing; Morris E. Thomas, Indianapolis; Charles E. Geckler, Muncie; A.S. Kobak, Valparaiso; Thomas G. Hamilton, Columbia City; Jack W. Hannah, Elkhart; Chester A. Stayton, Jr., Indianapolis and Willard Barnhart, Evansville.

Their meetings have underlined the importance of economics and insurance management in medicine today. Their interest and industry was vigorous and sustained; and yet they would all agree that the surface of the many problems confronting the physicians of Indiana was barely scratched.

In an effort to make the approach more comprehensive, four subcommittees were formed so that more careful scrutiny of a few commission members might be given to each issue raised. The subcommittees were: (a) Group Insurance Plans for ISMA Members; (b) Outpatient Insurance Coverage; (c) Group Practice; and (d) Health Insurance Availability.

A meeting with Mr. Oscar Ritz, the Insurance Commissioner of the State of Indiana, helped to determine the feasibility of many different programs suggested by members of the commission.

The accomplishments and goals will be summarized briefly. The disability insurance program for ISMA members was enlarged to provide coverage through the Continental Casualty Company for those members not previously eligible for benefits for whatever reason. The ready availability of this disability program to new members of the ISMA was confirmed. Attempts are being made to clarify the extent to which outpatient investigative and treatment procedures should be and will be covered by most medical insurance plans. The malpractice problem is being studied intensely. All members of the ISMA should be aware that the commission may be able to provide a group malpractice coverage for all members of the ISMA if a sizeable percentage of the membership will enroll in the program. Other methods of voluntary coverage for membership are being alternately studied. Suggestions and opinions of the membership on this problem of malpractice insurance coverage will be greatly appreciated by this commission. The possibility of still other group coverages for the membership are not being overlooked and it is hoped they will be presented in one big package when the malpractice problem is clarified.

The recent legislative move toward allowing physicians to incorporate has made the future of group practice in Indiana a bright one. The possibility that the delivery of medical care to Hoosier citizens might be thereby enhanced makes more important this new opportunity for physicians to form professional corporations. The commission is interested in providing this information to the membership and would appreciate the thoughts of the members on the choice of a formal presentation at convention time vs. a mailing of particulars.

All-in-all, the plight of the provider and consumer of medical care in Indiana is being continually analyzed and changes for the better will hopefully be provided. The great expanse of this field in recent years is fascinating and foreboding. The members of this commission certainly can report that if nothing else is achieved they are becoming better informed.

THOMAS J. CONWAY, M.D., *Chairman*
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MORRIS E. THOMAS, M.D.
CHARLES E. GECKLER, M.D.
A. S. KOBAK, M.D.
THOMAS G. HAMILTON, M.D.
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CHESTER A. STAYTON, JR., M.D.
WILLARD BARNHART, M.D.

Medical Education and Licensure

The Commission on Medical Education and Licensure has met twice thus far in 1969, the meetings being held on January 26 and May 18.

At our first meeting we were honored to have as guests two members of the Student American Medical Association, Michael D.

Cashman and Robert Steel.

Doctor Lukemeyer reported to the commission on the availability of speakers from the Indiana University School of Medicine. Also, under the Indiana Plan, the medical school now has 30 video tape centers and equipment in 15 cities, which are being utilized for postgraduate education. Television stations in Terre Haute, Evansville, Fort Wayne, Lafayette, Elkhart, South Bend, Gary and Muncie will be utilized starting in September for live hospital medical programs for physicians.

The preceptor program continues to be very successful. It is under the direction of Dr. William Ringer of Williamsport. Dr. Ringer has recently reviewed and brought up to date the list of approved preceptors, which now includes 74 physicians. It is the recommendation of this commission that recognition for their efforts be given the preceptors, both in our *Journal* and in the form of individual certificates.

The commission went on record as supporting the State Board of Medical Registration's proposals to increase the licensing examination fee in Indiana to $75 and to give a machine-graded type of examination, replacing the previous hand-graded one.

Discussion has taken place with regard to conducting a survey of medical and paramedical personnel needs in Indiana. However, it is the commission's feeling that this is a large undertaking and should be done by a professional staff.

The commission has wholeheartedly endorsed the Indiana Plan.

Dr. Lowell Steen has requested that the commission compile a list of speakers available for speaking on subjects pertinent to medicine. This is being done at the present time and hopefully will be available soon.

Doctor Irwin reported that the university has started a section of community medicine.

The commission is now studying the reports from the Oregon and California Medical Associations in regard to continuing medical education for physicians, particularly their views toward relicensure and recertification. Discussion will occur at our next meeting.

Dr. Lowell Steen, president-elect of the Indiana State Medical Association, communicated to the commission some of his thoughts. These included physician's attitudes toward learning; the medical audit in continuing education; home study courses; dial access tapes; computer assisted instruction; newer techniques in programmed instruction; live two-way television conferences; and self-assessment programs. We thank Dr. Steen for his interest in and emphasis on continuing medical education.

I wish to thank the commission members for their loyalty and continued support.

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Chairman

FRANKLIN BRYAN, M.D.,
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GEORGE T. LUKEMEYER, M.D.
WILLIAM RINGER, M.D.
LEO RADIGAN, M.D.
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JENE R. BENNETT, M.D.
MERRITT O. ALCORN, M.D.
PETER J. PILECKI, M.D.
GLENN W. IRWIN, JR., M.D.,
(*Ex-Officio*)

Special Activities

The Commission on Special Activities met twice this year. An extensive study into the relations with foreign medical graduates was made during a very informative session spent with Dr. Antonio Donesa of Fort Wayne, Indiana. Dr. Donesa is the secretary for the National Foreign Graduate Association. He advanced the problems and adversities met by the foreign medical graduate in his attempt to practice in the United States and Indiana in particular. He also gave concrete ideas on how to eliminate many of the unfair obstacles and yet maintain the highest standards of medical practice in Indiana.

The commission considered Dr. Donesa's proposals and the changes we felt were warranted were then recommended to Dr. Merritt O. Alcorn, vice president of the State Board of Medical Registration and Examination of Indiana. We were most gratified to find that positive programs and testing methods to rectify many of the inequities have been introduced or will be in the near future. For a further discussion of this work see the minutes of the April 27, 1969 meeting of the Commission on Special Activities.

The commission also started work on a study of the accreditation of hospitals by the Joint Commission on Hospital Accreditation. This is a complex problem and will need to be pursued further in commission meetings next year. Preliminary studies are now under way by commission members. Dr. Ray H. Burnikel of Evansville and Dr. Harold C. Ochsner of Indianapolis.

Dr. William H. Garner, Jr., secretary of the commission, forwarded letters pledging our help to the Commission on Public Information on joint problems and aid to the woman's auxiliary in the consideration of rehabilitation and the auxiliary's renewed interest in encouraging young people to seek a career in the health fields.

The commission also wants the Indiana State Medical Association to have more say in consideration of road and highway safety in this state. Many of the present glaring errors could have been prevented by the active participation of a physician, familiar with these problems, on the State Highway Commission. Therefore, this commission recommends to the Board of Trustees of the ISMA that an all out effort be made to place such a physician on the Indiana State Highway Commission.

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HENRY BIBLER, M.D.
ADOLPH WALKER, M.D.
EVERETT F. DONNELLY, M.D.
K. G. HILL, M.D.
ROBERT P. ACHER, M.D.
NORBERT WELCH, M.D.
FRED C. POEHLER, M.D.
FRED E. HAGGERTY, M.D.

Aging

This year the commission took for its theme the concept of "preventive geriatrics." This idea had been touched upon in preceding years but had not been developed. It must be acknowledged here that it still has not been "developed" but is as yet more of a latent image. Actually, it is a needed support in the foundation of "independent living" which has been emphasized for years as a continuing goal for the aging and the aged, not only by this commission, but also by the Indiana State Commission on the Aging and Aged, and by the State Board of Health.

The surface of this field has only been scratched, since it is really more complex than its name, or designation, would indicate. There are many problems of retirement at age 65 in relation to emotional shock, waste of manpower, waste of experience, etc., which are thrust upon society by such an arbitrary policy. These effects are not found in every case, but they do occur in a high percentage of the retired.

If the aged are to enjoy independent living they must be mentally able to do so. It is likely that many would benefit from mental preparation for retirement some time before the event. This might be considered as a sort of preventive rehabilitation.

As aging proceeds—at unpredictable rates in different individuals—physical changes multiply and assert themselves. If independent living is to continue, these effects must be combatted, and the aging one will need help in caring for his health. Home health care is recognized as offering the greatest rewards, but has received less attention than the more dramatic development of extended hospital care (so-called "Extended Health Facilities"), nursing homes (really, custodial care) and "retirement homes." The development of home health care by such means as home health aides, Homemakers, "meals on wheels", etc., has been quite spotty—well along in some communities, lacking in others. Among its other projects, the commission maintains interest in promoting availability of home health care, not only for the indigent and "medically indigent" but also for those who can afford to pay. Personnel seems gradually to be becoming more available, as witness the fact that the State Board of Health has trained 620 nurses in the elementary principles of rehabilitation. Among these were nurses from 109 nursing homes, but only two county homes participated. Homemakers and home health aides are in short supply in many places. It must be recognized that home health care is not limited to those past a certain age, but by and large the majority of those needing it will be among the elderly.

The commission feels, and wishes to emphasize, that for the maintenance of high standards of care in extended health facilities, in nursing homes and in county homes, no amount of rules and regulations can equal in effectiveness the alert and continued medical supervision of their patients by the physicians of Indiana. The physician must be in control at all times. Dr. A. C. Offutt, State Health Commissioner, states that his experience in dealing with health facilities has been. . . "That patient needs are met in those cases in which medical supervision is maintained and the physician-patient relationship is perpetuated as inviolate."

These considerations have led the commission to formulate a resolution to be presented to the House of Delegates, as follows:

WHEREAS, the Commission on Aging of the Indiana State Medical Association has considered conditions which presently exist in many of Indiana's nursing homes, and,

WHEREAS, members of the commission have been advised of actual instances of poor administration and substandard care in many nursing homes, which may be due to the necessity of the administration recommending and supervising rehabilitation procedures, and,

WHEREAS, it is evident that in the interest of good medical treatment of older patients, the physician must be primarily involved,

NOW, THEREFORE, BE IT RESOLVED, that members of the Indiana State Medical Association in order to exert greater influence in upgrading facilities and patient care be urged to maintain an active and continuing doctor-patient relationship with patients confined to all medical care facilities in addition to the acute general hospital facilities in the state.

Another impediment to independent living by the retired person on Social Security has been the limitation of earned income, as it inhibits the healthful and enjoyable activity of useful work and promotes a dreary outlook and a feeling of uselessness. Therefore, the commission has formulated another resolution, to be submitted to the House of Delegates, as follows:

WHEREAS, the Commission on Aging of the Indiana State Medical Association has been on record for several years as promoting the goal of independent living for the elderly, as long as they are capable of it, and,

WHEREAS, the limitation on earnings of those receiving Social Security benefits tends to discourage useful and profitable employment, and,

WHEREAS, this inhibits healthful and enjoyable activity and promotes a negative outlook,

NOW, THEREFORE, BE IT RESOLVED, that the ISMA petition the U.S. Senators and the Congressmen from the state of Indiana to initiate and/or to support the elimination of this impediment to independent living, and,

BE IT FURTHER RESOLVED, that such remedial action be made effective as soon as possible.

This commission met this year at Indianapolis on January 26, March 30 and June 1. Dr. George E. Davis, executive director of the Indiana State Commission on the Aging and Aged, attended two of these meetings, by invitation. His commission is handicapped in that it has no field personnel and is not in good contact with what is going on throughout the state. He feels that education of the general public should have top priority, and that senior citizen centers offer a good place from which to work. A plan is afoot to choose one county for long-term development in preventive action, calculated to promote independent living. This pilot study would require personal interviews rather than questionnaires by mail, etc. Also, he cautioned against lumping the chronically ill and the aged in one group. He too emphasized homemaker and home care services.

Amid all of these perplexities and problems, your commission chairman would like to inject here a philosophical suggestion which should help to maintain a proper perspective: never complain too much of old age—it is a privilege denied to many.

The entire commission joins in thanks to the ISMA Headquarters Office, for their help behind the scenes.

A. W. CAVINS, M.D.,
Chairman
W. R. VAN DEN BOSCH, M.D.,
Vice-Chairman
RAYMOND DUNCAN, M.D.,
Secretary
BERNARD B. ROSENBLATT, M.D.
R. E. BUCKINGHAM, M.D.
JOHN O. BUTLER, M.D.
GEORGE M. YOUNG, M.D.
GEORGE W. WAGONER, M.D.
NATHAN SALON, M.D.
THOMAS A. ELLIOTT, M.D.
ANDREW C. OFFUTT, M.D.
MARVIN E. HAWES, M.D.
JAMES R. GUTHRIE, M.D.
WENDELL C. ANDERSON, M.D.

Emergency Medical Services

The Commission on Emergency Medical Services was organized in January, 1969, and held subsequent meetings in February, March and May.

Administrative support has been provided by Mr. Kenneth Bush and has been excellent. For the meetings we adopted the dual format of an informational report on particular problems followed by a planning session. By this method it has been possible to advise and inform the members of the commission and simultaneously to begin working toward the commission's goals.

Reports were received from representatives of private and municipal ambulance services, emergency radio communications representatives and emergency telephone system specialists. An entire meeting was devoted to the evolution of a plan

for highway directional road signs to emergency medical services.

In April, we held a joint meeting with members of the State Health Planning Council. At their request we made the preliminary selection of community hospitals which should be developed into regional trauma centers. This list is as follows:

Region 1. Marion County General Hospital, Community Hospital of Indianapolis, Methodist Hospital—Indianapolis

Region 2. St. Elizabeth's—Lafayette

Region 3. St. Margaret's—Hammond
Methodist Hospital of Gary, LaPorte Hospital

Region 4. Memorial Hospital of South Bend, Elkhart General Hospital

Region 5. Lutheran Hospital—Fort Wayne

Region 6. St. Joseph's Hospital—Kokomo

Region 7. Grant County Hospital—Marion
Ball Memorial Hospital—Muncie

Region 8. Reid Memorial—Richmond

Region 9. University Hospital—Cincinnati

Region 10. Bartholomew County—Columbus
Bloomington Hospital

Region 11. Baptist Hospital—Louisville

Region 12. Deaconess Hospital—Evansville

Region 13. St. Anthony Hospital—Terre Haute

We secured the endorsement of the Board of Trustees for:

(1). The Hospital Emergency Administrative Radio System (Motorola Corp.).

(2). The 911 Emergency Telephone Number (Bell System).

(3). The "Sign of Life" for Indiana highways.

Members of our commission have begun the preliminary planning for local emergency radio nets. Members of our state staff skillfully guided a resolution in the legislature promoting 911. We have a working relationship with Indiana Bell executives which should lead to further action on 911. We have secured local, state and federal consent for a demonstration highway sign project in emergency service region number five.

We had planned to have a preliminary feasibility study of air evacuation methods, but have not yet achieved this. It is important to know the newest air ambulance equipment and operating techniques. However, technical and professional study should be concentrated on whether it is practical or possible to have such service. It is the consensus of our commission, and the experts whom we have consulted, that legislative efforts to upgrade ambulance operations are necessary. We believe that ISMA should lead this effort, rather than other professional or lay groups.

We suggest that ISMA should make a stronger effort in the field of accident prevention. There is a need for leadership in the effort to reduce drunk driving and to exclude the habitual traffic offender, the psychopath, and the physically disqualified from gaining the driving privilege. There is, even now, too little effect from the campaign for the use of seat and shoulder belts and other safety devices. Who understands these problems better than the doctors who provide care for the accident victims? Certainly our profession can provide the skill and energy to translate plans and programs into effective community action.

Our final commission meeting will take place in September. It will be devoted to preliminary planning for a statewide ambulance ordinance to be presented to the Board of Trustees and the Commission on Legislation prior to the 1971 legislature.

JOHN S. FARQUHAR, JR., M.D., *Chairman*
RAYMOND W. NICHOLSON, M.D., *Vice-Chairman*
ROBERT M. BROWN, M.D., *Secretary*
WILLIAM F. KERRIGAN, M.D.
ROLLA D. BURGHARD. M.D.
R. JAMES BILLS, M.D.
JAMES D. FINFROCK, M.D.
CHARLES A. RAU, M.D.
MELVIN D. COOK, M.D.
LARRY W. SIMS, M.D.
JAMES W. KRESS, M.D.
WILLIAM W. DRUMMY, M.D.
FREDERIC L. SCHOEN, M.D.
FORREST J. BABB, M.D.
NEAL E. BAXTER, M.D.

Resolutions

Amendments to the Constitution to be Voted on at Indianapolis Session, 1969

At the 1968 annual convention at Fort Wayne, the House of Delegates adopted the report of the Reference Committee on Amendments to the Constitution and By-laws, in which the Reference Committee recommended for adoption the following amendments to the Constitution:

Be it resolved that Article IV, Section 1 of the Constitution be amended so as to read:

"Section 1. This association shall consist of active members, associate members, senior members, honorary members and disabled members." (This merely adds a classification of disabled members to this section of the Constitution.)

Be it resolved that Article IV, Section 6 of the Constitution be amended to become Article IV, Section 7 and that a new Article IV, Section 6 be added to the Constitution to read as follows:

"Section 6. —Disabled Members. Disabled members shall consist of physicians of the state of Indiana who are certified by a member physician to be permanently disabled and no longer able to practice medicine and who continues to reside in the state of Indiana.

"Proof of permanent disability shall be by notification of the secretary of the association by the secretary of the county medical society in which such permanently disabled physician holds membership."

Be it resolved that a new subsection be added to Article IV, Section 7 of the Constitution to read as follows:

"e. All such disabled members, as defined above, shall receive association membership cards and *The Journal* of the association without charge."

Resolution No. 69-1

Introduced by: DAVIESS-MARTIN COUNTY MEDICAL SOCIETY
Subject: SEX EDUCATION
Referred to: REFERENCE COMMITTEE #5

WHEREAS, the proponents of sex education have influenced a few medical societies to sanction their program in grade schools, and,

WHEREAS, a careful study of those sex programs indicates that their principal purpose is to further deteriorate the morals of our youth,

NOW, THEREFORE, BE IT RESOLVED, by the Daviess-Martin County Medical Society in special session this 2nd day of June, 1969, that it expresses its opposition to the SIECUS type of sex education, and requests the Indiana State Medical Association to do likewise.

Resolution No. 69-2

Introduced by: COMMISSION ON AGING
Subject: PHYSICIAN RELATIONS WITH MEDICAL CARE FACILITIES
Referred to: REFERENCE COMMITTEE #3

WHEREAS, the Commission on Aging of the Indiana State Medical Association has considered conditions which presently exist in many of Indiana's nursing homes, and,

WHEREAS, members of the commission have been advised of actual instances of poor administration and substandard care in many nursing homes, which may be due to the necessity of the administration recommending and supervising rehabilitation procedures, and,

WHEREAS, it is evident that in the interest of good medical treatment of older patients, the physicians must be primarily involved,

NOW, THEREFORE, BE IT RESOLVED, that members of the Indiana State Medical Association in order to exert greater influence in upgrading facilities and patient care be urged to maintain an active and continuing doctor-patient relationship with patients confined to all medical care facilities in addition to the acute general hospital facilities in the state.

Resolution No. 69-3

Introduced by: COMMISSION ON AGING
Subject: INDEPENDENT LIVING
Referred to: REFERENCE COMMITTEE #4

WHEREAS, the Commission on Aging of the Indiana State Medical Association has been on record for several years as promoting the goal of independent living for the elderly, as long as they are capable of it, and,

WHEREAS, the limitation on earnings of those receiving Social Security benefits tends to discourage useful and profitable employment, and,

WHEREAS, this inhibits healthful and enjoyable activity and promotes a negative outlook,

NOW, THEREFORE, BE IT RESOLVED, that the ISMA petition the U.S. Senators and the Congressmen from the state of Indiana to initiate and/or to support the elimination of this impediment to independent living, and,

BE IT FURTHER RESOLVED, that such remedial action be made effective as soon as possible.

Resolution No. 69-4

Introduced by: COMMISSION ON PUBLIC HEALTH
Subject: SEX EDUCATION
Referred to: REFERENCE COMMITTEE #5

WHEREAS, the problems of sex and venereal disease education in the public school system as well as use and abuse of dangerous drugs, especially among school-aged youth during the past year, have been studied in depth by the Commission on Public Health, and,

WHEREAS, these studies have revealed an ever-increasing effort by groups at the national level to impose ideologies, which, in essence, attempt to divorce morality from sexual relationships in their proposed courses, and,

WHEREAS, these studies have further revealed that there is a virtual deluge of pornographic literature being circulated through the mails to the youth of this state, and,

WHEREAS, the concern of the Commission on Public Health is further amplified by President Nixon's announcement in 1969 of the need for stemming the flow of these unwholesome and deteriorating influences, and,

WHEREAS, at present there is an excellent storehouse of films and literature on the subjects of sex, venereal disease, and dangerous drugs available to the public school system in Indiana from the Indiana State Board of Health and the American Medical Association,

NOW, THEREFORE, BE IT RESOLVED, that this House of Delegates support the proposition that education in our schools on the subjects of sex, venereal disease, and dangerous drugs is a local affair and as such should be locally guided, encouraged, and controlled by the parents, clergy, physicians, teachers, and interested citizens of the concerned community, and,

BE IT FURTHER RESOLVED, that this House of Delegates encourage its members to make themselves available to support and participate in any local training or instructional programs to assist teachers or school health personnel on the subjects of sex, venereal disease, and dangerous drugs, and,

BE IT FURTHER RESOLVED, that local educational units be encouraged to make use of the materials on the aforementioned subjects that are available from the Indiana State Board of Health, the Indiana State Medical Association and the AMA, and,

BE IT FURTHER RESOLVED, that

this House of Delegates go on record as being opposed to the use in our schools of any materials or curriculum guides prepared by, at the recommendation of, or under the supervision of the organization called SIECUS (Sex Information and Education Council of the U.S.) or its affiliates; and as being opposed to any SIECUS involvement in "teacher preparation," and,

BE IT FURTHER RESOLVED, that the Indiana State Medical Association formulate a position statement which permits retention of traditional Judeo-Christian concepts in school instruction in subjects of sex, venereal disease, and dangerous drugs; this to be done in cooperation with the Indiana State Board of Health and the Department of Public Instruction in Indiana to aid in carrying out the full intent of this Resolution.

Resolution No. 69-5

Introduced by: FUTURE PLANNING COMMITTEE
Subject: WORKING RELATIONSHIPS WITH SPECIALTY GROUPS
Referred to: REFERENCE COMMITTEE #2

RESOLVED, that the Committee on Future Planning recommends to the Indiana State Medical Association House of Delegates that appropriate action be taken to (a) make available to specialty organizations (this includes Academy of General Practice) in Indiana the secretarial and mailing facilities of ISMA and (b) encourage specialty sessions in conjunction with and coordinated with ISMA meetings. Each specialty group would then be responsible for their scientific session. ISMA might then elect to sponsor no scientific sessions of its own.

Resolution No. 69-6

Introduced by: FUTURE PLANNING COMMITTEE
Subject: STRENGTHENING THE PROFESSION
Referred to: REFERENCE COMMITTEE #2

RESOLVED, that the Committee on Future Planning recommends to the Indiana State Medical Association House of Delegates that they sponsor a committee with appropriate representatives from all M.D. organizations in Indiana with the mission of:

(a) Exploring the feasibility of all organizations merging into a single federation under ISMA.

(b) Formulate a plan for accomplishing this and giving all groups an equitable representation in the ISMA House of Delegates and trustees.

(c) Explore the feasibility of defining units, other than only counties, as equivalent units within ISMA. (For example, a large hospital staff, a geographic region with common interests, a large specialty group, etc.)

Resolution No. 69-7

Introduced by: FUTURE PLANNING COMMITTEE
Subject: METHOD OF ELECTION OF CERTAIN OFFICERS
Referred to: REFERENCE COMMITTEE #2

RESOLVED, that the Committee on Future Planning recommends to the Indiana State Medical Association House of Delegates that the Constitution be amended to include the following ways of getting new, wider and more active participation of the membership:

(a) ISMA trustees and AMA delegates and members of the ISMA House of Delegates be elected by a vote of the entire membership which they represent.

(b) All elections should be by mail ballot.

(c) At least two candidates, for every trustee and delegate office, be submitted by the nominating committee.

(d) To win a candidate must have 35% plurality of the entire membership —not just a majority of the votes cast. If the candidate receives less than the 35%, the election would be invalid and a new election would be held.

(e) A trustee and a delegate can be re-elected for a maximum of three terms in succession. He must then remain a non-candidate for the same office for one term before seeking that office again.

Resolution No. 69-8

Introduced by: FUTURE PLANNING COMMITTEE
Subject: MEDICAL LIABILITY LIMITS
Referred to: REFERENCE COMMITTEE #4

RESOLVED, that the Committee on Future Planning recommends to the Indiana State Medical Association House of Delegates that legislation be prepared for presentation to the Indiana State Assembly by interested members of that assembly to combat on a legal basis the ever-increasing problems of medical liability.

One specific recommendation is that legislation be prepared for use of medico-legal panels for pre-trial investigation. Another should be designed to correct the abuses associated with the contingency fee concept.

Resolution No. 69-9

Introduced by: DAVIESS-MARTIN COUNTY MEDICAL SOCIETY
Subject: MEDICAL CARE AS A SERVICE—NOT A RIGHT
Referred to: REFERENCE COMMITTEE #5

WHEREAS, many physicians have been influenced by propaganda to repeat the socialist cliche that medical care is a right, and,

WHEREAS, there could be no medical care unless individuals expended the time, money and personal energy necessary to acquire the knowledge to practice medicine for the needs of the ill and for their own sustainance, and,

WHEREAS, the ability to practice medicine is the property of an individual, it cannot rightfully be taken from him and given to another person without his consent except by violation of the basic rights of ownership,

NOW, THEREFORE, BE IT RESOLVED, that the Daviess-Martin County Medical Society in regular session this 21st day of July, 1969, goes on record as opposing the fallacy of medical care as a right and requests such a resolution be adopted by the ISMA at its October 1969 session, and,

BE IT FURTHER RESOLVED, that we consider medical care to be a service that can be purchased by those who seek it, or can be freely given by the physician, to those who cannot pay for it.

Resolution No. 69-10

Introduced by: FORT WAYNE (ALLEN COUNTY) MEDICAL SOCIETY
Subject: UNETHICAL ADVERTISING
Referred to: REFERENCE COMMITTEE #4

WHEREAS, the ethics of the great majority of persons who hold licenses in the healing arts prohibit advertising, and,

WHEREAS, the few who do advertise their healing arts are frequently perpetrating fraud upon the public, and,

WHEREAS, several state legislatures, including Illinois and Kentucky, have seen fit to make healing art advertising illegal.

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association urge our state legislature to prevent advertising of implied claims in the healing arts and to limit public announcements to no more than an annual notice of office location and hours, or a change in office location or hours, or a change in professional association within an office.

Resolution No. 69-11

Introduced by: MARION COUNTY MEDICAL SOCIETY
Subject: PHYSICAL EXAMINATIONS FOR SCHOOL EMPLOYEES
Referred to: REFERENCE COMMITTEE #5

WHEREAS, the 1969 Indiana General Assembly amended the Acts of 1949, c. 157, s. 810, as amended by the Acts of 1959, c. 34, s. 1, to make it unlawful for school authorities "to employ administrative personnel, clerical personnel, teachers, janitors, maintenance personnel, bus drivers or food handlers who are addicted to drugs, or who are intemperate, or who have tuberculosis or syphilis in an infectious stage," and,

WHEREAS, the statute requires an *annual physical examination* "for tuberculosis, including adequate laboratory tests and diagnostic x-rays" prior to employment of such personnel on a permanent or temporary basis, and,

WHEREAS, requirement of an *annual physical examination*, if the phrase were interpreted literally, would be impractical and prohibitively costly for school administrations,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association be urged to seek amendment of the 1969 amendment to provide only that a Mantoux intradermal skin test for tuberculosis be required, and then only for school personnel having contact with pupils; that reactors be referred to private physicians for further examination and testing, and that the school authorities concerned be advised of the results of the testing.

Resolution No. 69-12

Introduced by: MARION COUNTY MEDICAL SOCIETY
Subject: INSURED AMBULATORY DIAGNOSTIC BENEFITS
Referred to: REFERENCE COMMITTEE #4

WHEREAS, medical diagnosis is an integral part of the practice of medicine and diagnostic services are physicians' services, and,

WHEREAS, the provision of so called "pre-admission testing" by Blue Cross Plans involves provision of diagnostic medical services to ambulatory patients, and,

WHEREAS, provision of pre-admission testing under hospital care insurance limits the site of service to the hospital and payment for this service to the hospital, and,

WHEREAS, these restrictions inhibit attending physicians in selecting where and to whom to refer patients for these medical services, and,

WHEREAS, these restrictions discriminate against the independent practice of radiology by physicians in offices and in hospitals, and,

WHEREAS, the insurance of medical benefits is the purpose of Blue Shield Plans and commercial medical care insurers, and,

WHEREAS, provision of insured ambulatory diagnostic benefits eliminates some medically unnecessary occupancy of hospital beds, and,

WHEREAS, ambulatory diagnostic benefits are desired by patients, have been recommended by spokesmen for government, labor and management, and will be made available through pre-payment,

NOW, THEREFORE, BE IT RESOLVED, that the House of Delegates of the Indiana State Medical Association requests and urges Blue Shield Plans and other insurers of physicians' services in Indiana to aggressively extend provision of ambulatory benefits to those insured, and,

BE IT FURTHER RESOLVED, that the Indiana State Medical Association notes that provision of ambulatory diagnostic benefits by Blue Cross and insurers of hospitalization restricts patients and physicians in freely selecting where these medical services will be accomplished and by whom.

Resolution No. 69-13

Introduced by: MARION COUNTY MEDICAL SOCIETY
Subject: PHYSICIAN SHORTAGE
Referred to: REFERENCE COMMITTEE #3

WHEREAS, there continues to be a shortage of physicians in Indiana, especially in rural areas and in urban areas of low economic classification, and,

WHEREAS, provision of such medical services and the retention of physicians are a joint responsibility of the medical profession and the community in Indiana, and,

WHEREAS, individuals and organizations throughout the state, outside the medical profession, cognizant of these needs, are increasingly appealing to organized medicine for assistance in these areas of concern, and,

WHEREAS, the urgency of developing constructive programs to meet these appeals for the delivery of health services is now paramount,

NOW, THEREFORE, BE IT RESOLVED, that the House of Delegates of the Indiana State Medical Association refer the problem of the establishment of such services, as well as the retention of physicians in Indiana, to the Board of Trustees, and,

BE IT FURTHER RESOLVED, that the Board of Trustees be prepared to report back to the October, 1970, House of Delegates with a statement of their accomplishments and possible solutions.

Resolution No. 69-14

Introduced by: MARION COUNTY MEDICAL SOCIETY
Subject: MEDICAL EDUCATION
Referred to: REFERENCE COMMITTEE #3

WHEREAS, the Indiana Plan for Medical Education has shown progressive growth since its inception, and,

WHEREAS, incorporated into the plan, have been new concepts to keep pace with the increasing pressures of the public and government for the delivery of health services to all with the highest degree of economy and maintenance of quality, and,

WHEREAS, the aims of the Indiana Plan, as originally established, are being accomplished, with a steady progression of new imaginative programs, and,

WHEREAS, these aims have been delineated as follows:

1. To Provide Effective Medical Education for a Large Student Body;
2. To Provide a Wider Variety of Educational Opportunities;
3. To Increase the Number and Quality of Internship and Residency Programs in Indiana;
4. To Help Practicing Physicians in the State to Maintain a High Level of Professional Competence;
5. To Provide in Several Localities Experience in Formal Medical Education;
6. To Encourage Young Physicians to Practice in Indiana;

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association reaffirm its strong endorsement of the Plan, and request the Board of Trustees of the association to maintain constant liaison with the Indiana University School of Medicine with the objective of lending continuous support and assistance to the Plan's present and future needs, and,

BE IT FURTHER RESOLVED, that the Board of Trustees report to the House of Delegates at the October, 1970, Convention of its efforts in aiding in the implementation of the Plan.

Resolution No. 69-15

Introduced by: MARION COUNTY MEDICAL SOCIETY

Subject: DELIVERY OF HEALTH CARE
Referred to: REFERENCE COMMITTEE #4

WHEREAS, events are continually taking place and decisions are being made in Washington which clearly indicate a pattern which is going to produce changes dramatic and fundamental in the delivery of health care, and,

WHEREAS, at a recent meeting a representative of the Department of HEW indicated the President told the nation's press that he knew the country's health care system was in deep trouble but he had not appreciated just how bad things really are, and,

WHEREAS, Dr. Egeberg is credited with having said "The condition is 'grave' tending to 'critical'," and the remedies that are called for will have to be fully appropriate to the condition they are meant to correct, and,

WHEREAS, the government is attacking the cost of health care as one means of reducing the cost of these programs, and,

WHEREAS, we continually hear rumors and comments that the method of delivery of health care so as to provide the quality and quantity of treatment by the public is still not adequate,

NOW, THEREFORE, BE IT RESOLVED, that the Board of Trustees be made to study all the whole question of delivery of health care which would include additional personnel; neighborhood clinics; provision of services in underprivileged areas; and the method of financing of such care, and,

BE IT FURTHER RESOLVED, that the Board undertake a comprehensive study of methods by which the profession can work with the insurance industry and the voluntary plans to provide a prepaid comprehensive health care program for the people of our state and report back with a plan for consideration of the House in 1970.

Resolution No. 69-16

Introduced by: MARION COUNTY MEDICAL SOCIETY
Subject: HEALTH MANPOWER
Referred to: REFERENCE COMMITTEE #3

WHEREAS, government planners and others have recognized the supply of health personnel is not adequate to meet the demand, and,

WHEREAS, at the recent meeting of the American Medical Association in New York City the American Medical Association concurs that the supply is not adequate to the demand, and that there is a maldistribution of health care personnel, and,

WHEREAS, it is evident that the government tends to place more and more people to various medical programs fostered by the government, and,

WHEREAS, the question of health manpower is one which is facing every segment of the practice of medicine,

NOW, THEREFORE, BE IT RESOLVED, that the Board of Trustees be charged with the responsibility of:

(1) Studying the question of provision of adequate health manpower;

(2) To maximize whatever productivity potentials do exist;

(3) Establish long-range goals of recruitment, utilization and training of specific types of health manpower;

(4) Validation, through health team studies, and consultation with concerned medical specialty societies, of the need for new helping roles in various segments of the health care system;

(5) Determination of whether existing categories of health manpower—with or without additional training—can fill these supportive roles or whether new types of personnel must be trained;

(6) Clarification of the legal and professional status and obligations of such new or existing personnel, their career needs and their supervisory relationship to the physician;

(7) Coordination with the activities of other elements of the health system, so as to identify common recruitment and training needs including the feasibility of core curricula, the potential for lateral and vertical mobility through development of educational continua and experience equivalents, and the immediate trade-offs necessary in terms of the overall manpower shortage;

(8) The possibility of increasing the supply of health manpower by studying ways to more effectively retain in the health field the highly trained military medical corpsmen and technicians being discharged into civilian life;

(9) To determine methods for appropriate training and licensing and certification of such personnel, and,

BE IT FURTHER RESOLVED, that the Board of Trustees of the ISMA report back to the House their findings, any recommendations or plans for consideration by this House at its 1970 meeting.

Resolution No. 69-17

Introduced by: MARION COUNTY MEDICAL SOCIETY
Subject: RELICENSURE OF PHYSICIANS
Referred to: REFERENCE COMMITTEE #3

WHEREAS, the President's Commission noted that "requirements of quality controls in formal education and licensure have been the primary means of assuring that physicians use the best techniques and information available. But with the increasing pace of medical advances these one time controls are not enough. The physician's education must be continued as long as he practices," and,

WHEREAS, the commission has recommended that "professional societies and state governments should explore the possibility of periodic relicensing of physicians and other health professionals. . . .," and,

WHEREAS, the American Medical Association as well as some other state associations have this matter under consideration,

NOW, THEREFORE, BE IT RESOLVED, that the Board of Trustees study and report and be responsible for a plan that would do the following:

(a) Establish a one year pilot program to test the feasibility of establishing association-wide continuing medical education requirements and that the program be similar to that of the American Academy of General Practice;

(b) That under this program the continuing medical education requirements be set at 50 hours or units each year;

(c) That each specialty group be given the responsibility of recommending the forms and programs of continuing medical education to be accredited for the field of practice and the unitage value;

(d) That meeting the continuing medical education requirements for the Academy of General Practice be considered equivalent to fulfilling the continuing medical education requirements;

(e) That special consideration be given to members who are not in common fields of practice, and that accredited courses outside a member's field of practice be allowed to apply to his general requirements;

(f) That the Board form a special advisory committee consisting of one member from the Indiana Academy of General Practice and one from each of the major specialty groups;

(g) That this committee give full consideration to every problem in which arbitration of any kind is needed;

(h) That this new committee have as its major function the administration of this program of continuing medical education requirements;

(i) That a study be made to require a proof of having participated for a given number of hours in continuing medical education as a prerequisite for a renewal of a license to practice medicine in this state.

Resolution No. 69-18

Introduced by: MARION COUNTY MEDICAL SOCIETY
Subject: CONTINUING MEDICAL EDUCATION
Referred to: REFERENCE COMMITTEE #3

WHEREAS, the Indiana State Medical Association and its component county medical societies have the responsibility to demonstrate to the citizens of Indiana that Indiana physicians possess the most modern medical knowledge, and,

WHEREAS, the Indiana State Medical Association and its component county medical societies have a primary responsibility to the citizens of Indiana to assure that the medical care rendered to them is of the highest quality. and,

WHEREAS, the American Medical Association has recognized that continuing medical education is a necessity in the modern day practice of medicine,

NOW, THEREFORE, BE IT RESOLVED, that this House of Delegates instruct the Board of Trustees to study this whole matter of methods of providing continuing certified education to the membership of this association and that they seriously consider making continuing medical education a requirement for membership in this association and on hospital staffs, and,

BE IT FURTHER RESOLVED, that the Board present to this House its findings and a recommended plan for this House to consider at its annual meeting in 1970.

Resolution No. 69-19

Introduced by: MARION COUNTY MEDICAL SOCIETY
Subject: PEER REVIEW
Referred to: REFERENCE COMMITTEE #4

WHEREAS, the American Medical Association has established a special Committee of Peer Review, and,

WHEREAS, Peer Review is becoming recognized as a suitable means of assuring the highest quality of medical care, and,

WHEREAS, medicine has been challenged to provide its own mechanisms for assuring the confidence and quality of medical care,

NOW, THEREFORE, BE IT RESOLVED, that this House of Delegates instruct the Board of Trustees to establish guidelines for Peer Review Committees and that the Board establish such a committee at the state level and urge each component county medical society of this association to immediately establish Peer Review Committees.

Resolution No. 69-20

Introduced by: GRANT COUNTY MEDICAL SOCIETY
Subject: COLLEGE HEALTH FORM
Referred to: REFERENCE COMMITTEE #3

WHEREAS, all colleges and universities require each new student to have physical examinations by physicians, and,

WHEREAS, each of these schools of advanced learning has a different form for this examination, and,

WHEREAS, at least one of these forms is quite difficult to read,

NOW, THEREFORE, BE IT RESOLVED, that the 1969 House of Delegates of the Indiana State Medical Association instruct the Board of Trustees to appoint a proper committee to meet with the Student Health Departments of at least all the state schools and possibly all those units of higher learning within the state to bring about a common form.

Resolution No. 69-21

Introduced by: BOARD OF TRUSTEES
Subject: CREATION OF SECTION ON COLLEGE HEALTH PHYSICIANS
Referred to: REFERENCE COMMITTEE #2

WHEREAS, college health physicians have indicated an interest in becoming more active within the Indiana State Medical Association, and,

WHEREAS, the creation of a Section on College Health Physicians would be a means of fostering closer relationship, and,

WHEREAS, the Board of Trustees concurs that this is an important segment in the delivery of health care to the younger people of our state,

NOW, THEREFORE, BE IT RESOLVED, that Chapter III, Section 1, of the Bylaws be amended by adding thereto the following: "n. College Health Physicians," renumbering the present line "n" to line "o."

Resolution No. 69-22

Introduced by: BOARD OF TRUSTEES
Subject: SAMA REPRESENTATION IN HOUSE OF DELEGATES
Referred to: REFERENCE COMMITTEE #2

WHEREAS, there is a need for the members of the Indiana State Medical Association to become more familiar with the activities of the Student American Medical Association at Indiana University School of Medicine, and,

WHEREAS, members of SAMA have shown great interest in the affairs of Indiana State Medical Association and American Medical Association by attendance and participation at meetings of various committees and commissions, at the Board of Trustees' meetings, and at the ISMA and AMA conventions, and,

WHEREAS, the elected officers of SAMA at I.U. Medical School have indicated a desire on the part of their members to become more active in Indiana State Medical Association, and,

WHEREAS, the AMA has granted the national SAMA representation in the AMA House of Delegates,

NOW, THEREFORE, BE IT RESOLVED, that the House of Delegates of Indiana State Medical Association grant the Indiana University Chapter of SAMA representation in its House of Delegates.

Resolution No. 69-23

Introduced by: BOARD OF TRUSTEES
Subject: INCREASE IN ANNUAL DUES
Referred to: REFERENCE COMMITTEE #5

WHEREAS, inflation has seriously diluted the purchasing power of our dues dollar, and,

WHEREAS, expansion of our staff and activities has increased the budget to the point where present income from dues will barely meet our expenses, and,

WHEREAS, valuable employees must be given adequate salary increases if their services are to be retained, and,

WHEREAS, there are desirable new programs contemplated by the officers and Board of Trustees which will require additional income for implementation,

NOW, THEREFORE, BE IT RESOLVED, that the House of Delegates of ISMA increase the annual dues in the amount of $10.00 effective 1 January, 1970.

Resolution No. 69-24

Introduced by: BOARD OF TRUSTEES
Subject: REPORTING ON FINANCIAL STATUS
Referred to: REFERENCE COMMITTEE #5

WHEREAS, inflation has seriously diluted the purchasing power of the dollar, and,

WHEREAS, our last state dues increase was in 1964, and,

WHEREAS, our Board of Trustees and staff has repeatedly effected substantial economy in our operations,

NOW, THEREFORE, BE IT RESOLVED, that the Board of Trustees report each year to the House of Delegates a recommendation as being an appropriate escalation in the dues structure based upon the Consumers Price Index, as promulgated by the U.S. Bureau of Statistics of the U.S. Department of Labor.

Scientific Exhibits

JOHN L. FERRY, M.D., Hammond, Chairman

DIAGNOSTIC CORONARY ARTERIOGRAPHY

Exhibitor: Charles M. Wunsch, M.D., Indianapolis
Co-Exhibitor: Community Hospital of Indianapolis, Indianapolis, Ind.
Attendants: Charles M. Wunsch, M.D., Ruth Washler, R.N. Essie Robinson, L.P.N.

The exhibit will display the materials used and the technic for performing retrograde coronary arteriography. In addition, the normal coronary arteriographic anatomy will be shown as well as the more frequently occurring acquired abnormalities.

EAT WELL . . . EAT WISELY . . . REDUCE YOUR RISK OF HEART ATTACK

Exhibitor: Indiana Heart Association, Indianapolis
Attendant: B. Pat O'Rourke

This eight foot unit of four panels will call to the attention of the public and professional people the Heart Association program relative to diet and heart disease, and the major changes in eating habits that are recommended. It highlights the two booklets that serve as a "daily food guide for the family" — "The Way to a Man's Heart, a Fat-Controlled, Low Cholesterol Meal Plan to Reduce the Risk of Heart Attack," and "Recipes for Fat-Controlled, Low Cholesterol Meals."

THE ROLE OF SURGERY IN CORONARY ARTERY DISEASE

Exhibitor: Harry Siderys, M.D., Indianapolis
Co-Exhibitor: John N. Pittman, M.D., Indianapolis, Ind.

Recent advances in coronary angiography have led to widespread interest in the role of surgery in patients disabled by coronary artery disease. Mammary artery implantation for angina has enjoyed gradually increasing popularity. More recently saphenous vein bypass around obstructed coronary arteries has been performed with success. With increasing experience, patients with symptomatic ventricular aneurysms resulting from myocardial infarction are being safely treated surgically.

The exhibit will present pictorial examples of these operations and the results obtained at the Methodist Hospital of Indiana.

INDIANA FLYING PHYSICIANS

Exhibitor: Indiana Flying Physicians Association
Attendant: Wymond B. Wilson, M.D.

Display will consist of a table with Indiana map to locate membership of the Indiana chapter. Brochures and membership applications in the Indiana Flying Physicians Association will be available.

OPERATION TO REVASCULARIZE THE HEART—LONG TERM RESULTS

Exhibitor: David S. Leighninger, M.D., Maple Heights, Ohio
Attendant: David S. Leighninger, M.D.

Long-term results of patients having heart revascularization operations by Beck and Leighninger are presented.

All patients operated upon (1,000) from 1954 through 1968 were classified according to pathological changes observed at operation.

Hospital mortality, late mortality and clinical results up to 15 years are presented.

It is thought the statistics indicate a reduction of mortality and morbidity due to coronary artery disease in patients treated by surgical operation.

DIAGNOSIS AND TREATMENT OF RHEUMATOID ARTHRITIS

Exhibitor: William R. Murray, M.D., San Francisco, Calif.
Co-Exhibitors: Committee on Arthritis, American Academy of Orthopaedic Surgeons; Mack L. Clayton, M.D., Denver, Colo.; Eugene Smoley, M.D., Sacramento, Calif.
Attendant: Designated representative of the American Academy of Orthopaedic Surgeons

The exhibit describes, in a fairly basic way, the diagnosis and treatment of rheumatoid arthritis. Both surgical and nonsurgical treatments are shown. We have used the wrist and knee as our representative joints and have demonstrated nonsurgical bracing and splinting as well as photographs and x-rays of wrists and knees before, during and after synovectomy, tendon transposition, arthrodesis, osteotomy and arthroplasty. Basic details of surgical technics are outlined.

INDIANA ACADEMY OF GENERAL PRACTICE MEMBERSHIP EXHIBIT

Exhibitor: Indiana Academy of General Practice
Attendants: Mrs. Jackie Schilling Mrs. Therese Koras

The Indiana Academy of General Practice exhibit will outline the benefits of membership, insurance programs, basic information concerning the American Boards of Family Practice. Applications for membership will be available as well as materials explaining the academy and its purposes.

PROSPECTIVE MEDICINE

Exhibitor: Robert P. Acher, M.D., Greensburg, Ind.
Co-Exhibitor: Lewis C. Robbins, M.D., Indianapolis
Attendants: Robert P. Acher, M.D., Lewis C. Robbins, M.D.

Physicians find change in their mode of practice to be difficult. Most physicians fail to change unless grim necessity forces them to make a change. The family physician has practiced episodic medicine with appropriate referrals. Tomorrow's medicine has so many opportunities for outright prevention that he must look at practicing medicine prospectively: diagnosing and treating risks. In other words, he must make a prognostic survey and attempt to affect prognosis. The exhibit contains a health appraisal manual, and assistants who will perform health appraisals on physicians. A second feature is a film strip on how Health Hazard Appraisal is performed. A third feature of the exhibit is the demonstration of computerization of a health appraisal.

POSSIBLE CAUSE OF PERSISTENT INFECTIONS

Exhibitor: C. W. Godzeski, Ph.D., Lilly Laboratory for Clinical Research, Marion County General Hospital, Indianapolis
Co-Exhibitors: H. R. Black, M.D., Indianapolis; G. L. Brier, B.S., Indianapolis

Bacterial infection may become chronic or recur because the causative organism undergoes transformation to a variant which can persist in the host. The variant is capable of surviving in spite of host resistance mechanisms and therapy with antibiotics or chemotherapeutic agents.

Numerous observations strongly indicate that these variants are L-phase bacteria.

The possible significance of L-phase bacteria, which will be emphasized in the exhibit, makes their inclusion in routine diagnostic procedures essential. However, the usual bacteriological methods cannot be used to isolate and propagate these aberrant forms. Appropriate procedures will be presented in detail. Furthermore, important characteristics and properties of L-phase bacteria in culture will be illustrated and discussed.

Procedures used in our laboratory have resulted in isolation of L-phase bacteria from numerous patients representing a variety of chronic infections. Data on two significant experiments will be reported in detail. L-phase staphylococcus was isolated from 11 patients with histories of long-standing infections. The L-phase variant slowly reverted to classical *Staphylococcus aureus* under appropriate laboratory conditions. L-phase bacteria were also isolated from heart tissue removed during open heart surgery in six of nine rheumatic fever patients; three were negative. The six L-phase isolates, after reverting to classical forms, were identified as four strains of *S. aureus*, a gram-negative rod, and a gram-variable rod. Under similar conditions no isolates were obtained from five patients with congenital heart defects.

The significance of these observations to chronic infections and antibiotic therapy will be illustrated and discussed.

INDIANA STATE ASSOCIATION OF MEDICAL ASSISTANTS

Exhibitor: Indiana State Association of Medical Assistants

Attendant: Mrs. Debbie McQuinn, Chairman

Booth will have information on Indiana State Association of Medical Assistants—Re: purpose, membership, limitation of activities.

PATIENT EDUCATION IN NUTRITION

Exhibitor: Dairy Councils of Indiana

Co-Exhibitors: Dairy Council, Inc., Indiapolis; Dairy Council of St. Joseph Valley, Inc., South Bend; Dairy Council of Kentucky and Southern Indiana, Evansville.

Attendants: Mrs. Nancy Rainey, Mrs. Sarah Chapella

Because of the importance placed today on the nutritional status of the American people, the Dairy Council display strives to assist the physician to interpret the value of the need for a balanced diet to his patients. We know that malnutrition exists in every financial bracket in this country. Therefore, Dairy Council feels that every physician should be knowledgeable about what constitutes a balanced diet. Nutritional surveys over the past several years have shown Americans, particularly teenage girls, are deficient in calcium, Vitamin A and ascorbic acid. By guiding these malnourished people to choose foods wisely, physicians can help to eliminate dietary deficiencies.

The Dairy Councils of Indiana hope that this display and the materials available will help the physician direct his patients to balanced meals and a stronger nutritional status.

STUDENT ACTIVISM 1969, THE POSITION OF THE MEDICAL STUDENT IN SOCIETY

Exhibitor: Student American Medical Association of Indiana University

Attendant: M. D. Cashman

This exhibit, sponsored by the Indiana University SAMA, utilizes audio-visual aid to describe some of the positions that today's medical students take in society. Emphasis is placed on the positive approach to answering problems that concern the medical student, the medical profession and society.

HEALTH MANPOWER RECRUITMENT

Exhibitor: Indiana Health Careers, Inc.

Attendants: Mrs. Jan Davidson, Mrs. Jancy Dorfman, Mr. Dennis Dawes, Mr. Chuck Tootle, Mrs. Maryann McCormick

Indiana Health Careers is a non-profit service organization which conducts a coordinated health manpower recruitment program for the state of Indiana. This program is supported by voluntary contributions from eighty-one (81) member organizations. These member organizations include professional associations, official and voluntary health agencies, Indiana Hospital Association, educational institutions, and to a limited extent, corporations.

The major emphasis of the program provides information to guidance counselors and students at the junior high, senior high, and college levels aimed at enticing them into the more than 200 health careers. This is accomplished through a clearing house of informational materials, the services and direction of staff consultants who are qualified to work in the classroom, the development and service of health careers clubs, a general statewide public relations campaign using all media, and through other appropriate resources. The organization is directed by a board of thirty (30) members with the assistance of a professional advisory council whieh is composed of a delegate from each of the member organizations.

The basic problem is success! The program has been accepted with enthusiasm to the extent that requests for services far exceed current ability to meet them because of financial limitations.

Technical Exhibitors—1969

ABBOTT LABORATORIES Booth 71
14th and Sheridan Rd. North Chicago, Ill.

ARNAR-STONE LABORATORIES, INC. Booth 90
601 E. Kensington Rd. Mt. Prospect, Ill.
James Cripps, William Snider

ASTRA PHARMACEUTICAL PRODUCTS, INC. Booth 69
7 Neponset St. Worcester, Mass.
David DeWine

AUTOMATED MANAGEMENT SYSTEMS OF INDIANA Booth 40
5015 Knoll Crest Ct. Indianapolis, Ind.
C. J. Ohlson, C. E. Kile, Alan Ball, Frank Howard

AYERST LABORATORIES Booth 32
685 Third Ave. New York, N. Y.

BAKER BROTHERS SALES & RENTALS Booth 51
2039 N. Capitol Ave. Indianapolis, Ind.

BRISTOL LABORATORIES Booth 4
P. O. Box 657 Syracuse, N. Y.
C. Roger Massa

BLUE SHIELD OF INDIANA Booth 1
110 N. Illinois St. Indianapolis, Ind.
(Free phone service for doctors wishing to call their offices or hospital anywhere in Indiana).
F. D. Harbridge

BURROUGHS WELLCOME & CO. (U.S.A.) INC. Booth 68
1 Scarsdale Rd. Tuckahoe, New York
J. M. Brown

CARNATION COMPANY Booth 7
5045 Wilshire Blvd. Los Angeles, Calif.
Clifford Schultz

CENTRAL BRACE & LIMB COMPANY Booth 54
1901 N. Capitol Ave. Indianapolis, Ind.
William Richardson, Richard Kearns, David Bokma, Robert McCulloch

CIBA PHARMACEUTICAL COMPANY Booth 77
556 Morris Ave. Summit, N.J.

COCA-COLA USA Booth 84
P. O. Drawer 1734 Atlanta, Ga.

CONTROL-O-FAX BEST BUSINESS PRODUCTS Booth 92
131 Hoss Rd. Indianapolis, Ind.
C. F. Cole, James Cole, Audra Cole, Bob Cronk, Keith Sidebottom

CURTIS & FRENCH, INC. Booth 41
1850 W. 15th St. Indianapolis, Ind.
Roy Watts, Wayne Hanson

DE PUY, INC. Booth 75
P. O. Box 988 Warsaw, Ind.
C. L. Welker

DICTAPHONE CORPORATION Booth 59
120 Old Post Rd. Rye, N.Y.
John Roseborough

D. M. DOYLE PHARMACEUTICAL COMPANY Booth 29
Highway 100 at W. 23rd St. Minneapolis, Minn.
Mike Writt

THE EMKO COMPANY Booth 73
7912 Manchester Ave. St. Louis, Mo.
Leslie Boehm

GEIGY PHARMACEUTICALS Booth 38
444 Saw Mill River Rd. Ardsley, N. Y.

IMPERIAL FASHIONS Booth 63
3959 W. 6th St. Los Angeles, Calif.

INDIANA BELL TELEPHONE COMPANY Booths 30 and 31
240 N. Meridian St. Indianapolis, Ind.
Russell M. Romine

INDIANA BRACE SHOP, INC. Booth 87
1815 N. Capitol Ave. Indianapolis, Ind.

INDIANAPOLIS PHARMACAL CO. Booth 91
3501 Brookside Parkway, S. Dr. Indianapolis, Ind.
Frank Saunders, Paul R. Lowe

INDIANA SURGICAL, INC. Booth 55
2851 N. Webster Ave. Indianapolis, Ind.
James J. Traub

LEDERLE LABORATORIES Booth 52
Pearl River, N.Y.
H. W. Thompson, J. E. Berck, T. J. Meier, N. B. Hugus, S. K. Bell, E. P. Paulus

ELI LILLY AND COMPANY Booth 46
P. O. Box 618 Indianapolis, Ind.
R. N. Thomas, P. A. Holsapple

ELI LILLY AND COMPANY Booth 43
307 E. McCarty St. Indianapolis, Ind.
Mitchell Kory, Ph.D.

MARION LABORATORIES, INC. Booth 86
10236 Bunker Ridge Rd. Kansas City, Mo.
Al Cushing

MEAD JOHNSON LABORATORIES Booth 88
2404 W. Pennsylvania Ave. Evansville, Ind.
Robert A. Terry, Glen Kesler, John Luhrsen

MEDCO PRODUCTS CO., INC. Booth 74
3601 E. Admiral Pl. Tulsa, Okla.
Jim Shores

THE MEDICAL PROTECTIVE COMPANY Booth 44
Fort Wayne, Ind.
Kenneth W. Moeller, Philip P. Capasso

MERCK SHARP & DOHME Booth 67
West Point, Pa.
Thomas P. Moriarty, William N. Miller

NORTH AMERICAN PHARMACAL Booth 2
6851 Chase Rd. Dearborn, Mich.
Jack Anderson, Jack Marx, Chuck Kohl, Richard Brachvogel, Don Swiggett

ORTHO PHARMACEUTICAL CORP. Booth 27
Raritan, New Jersey

PARKE, DAVIS & COMPANY Booth 5
GPO Box 118 Detroit, Mich.
D. O. Lamport, A. H. Griffin

PFIZER LABORATORIES Booth 72
235 E. 42nd St. New York, N.Y.

PHILIPS ROXANE LABORATORIES, INC. Booth 39
330 Oak St. Columbus, Ohio
Paul Urbanski

PROFESSIONAL MANAGEMENT Booth 70
2424 Fairfield Ave. Fort Wayne, Ind.
Paul Evans, L. Thomas Booth, Tommy Gregg, Jack Osborn, Joseph Parker, George White, Berton Bryna

QUAKER CITY PHARMACAL COMPANY Booth 65
1034 S. 54th St. Philadelphia, Pa.
D. James Wood

REX BUSINESS MACHINES CO. **Booth 8**
121 S. Pennsylvania St. Indianapolis, Ind.
Curt Benner

A. H. ROBINS COMPANY **Booth 48**
1407 Cummings Dr. Richmond, Va.
Bill Spangler, Mike Sifferlen

J. B. ROERIG DIVISION
(Chas. Pfizer & Co., Inc.) **Booth 64**
235 E. 42nd St. New York, N.Y.

WILLIAM H. RORER, INC. **Booth 60**
Fort Washington, Pa.
Joseph F. Cashen

SANDOZ PHARMACEUTICALS
Booth 6
Route #10 Hanover, N. J.
Dick Bennett, Herman King, Kenneth McCall

W. B. SAUNDERS COMPANY
Booth 66
7th and Locust St. Philadelphia, Pa.
Neil Rowe

SCHERING LABORATORIES
Booth 76
1011 Morris Ave. Union, N. J.

CLAYTON L. SCROGGINS ASSOCIATES **Booth 57**
200 Northland Blvd. Cincinnati, Ohio
Clayton L. Scroggins, Lee W. Scroggins, David C. Scroggins

G. D. SEARLE & CO. **Booth 49**
P. O. Box 5110 Chicago, Ill.
J. D. Kernodle, R. E. Fritz, G. C. Landers, R. W. Schulz, R. O. Voyles

SEVEN-UP BOTTLING CO., INC.
Booth 35
651 E. 20th St. Indianapolis, Ind.
Donald Hotze

SIEMENS MEDICAL of AMERICA, INC. **Booth 62**
60 West Faye Ave. Addison, Ill.
George Schaefer

SMITH KLINE & FRENCH LABORATORIES **Booth 53**
1500 Spring Garden St. Philadelphia, Pa.
Edward D. Porter, James H. Troyer, James A. Bova

SPENCER MEDICAL **Booth 34**
23 E. Ohio Street, #226
Indianapolis, Ind.
Mona Nevitt, Doris Thompson, Sharon Larmore

E. R. SQUIBB & SONS, INC.
Booth 47
909 Third Ave. New York, N.Y.
Lionel Lee

STUART DIVISION/ATLAS CHEMICAL INDUSTRIES, INC.
Booth 89
3360 E. Foothill Blvd. Pasadena, Calif.
Bob Smith, C. Knight

3M BUSINESS PRODUCTS SALES, INC. **Booth 28**
2445 E. 54th St. Indianapolis, Ind.
R. A. Ray

J. RUSSELL TOWNSEND, Jr., C. L. U.
Booth 45
Plans Administrator, CONTINENTAL CASUALTY INSURANCE
Indianapolis, Ind.
J. Russell Townsend, Jr., William F. Davis, Walter Fries, Mrs. Delores Penrod, Giles J. Phelps

THE UPJOHN COMPANY **Booth 85**
7000 Portage Rd. Kalamazoo, Mich.

VAN AUSDALL & FARRAR, INC.
Booth 42
2133 N. Meridian St. Indianapolis, Ind.
Jerry Smith, Clyde Von Grimmenstein, Jerry Mason, Russ Young, Jerry Wagner, Bob Moldthan, Jim Thomas, Fred Harris

WALLACE INVESTMENTS, INC.
Booth 50
6712 Calumet Ave., P. O. Box 4065
Hammond, Ind.
Don Scott, Don Oberholzer, Pete Hudson, John Keiser

WARNER-CHILCOTT LABORATORIES **Booth 33**
201 Tabor Rd. Morris Plains, N.J.

WINTHROP LABORATORIES
Booth 61
90 Park Ave. New York, N.Y.
Moody Cross, Wynne K. Porter

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cartridge – is premeasured.
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1. Select—from an extensive variety of prefilled Tubex sterile cartridge-needle units.* No multi-dose vials to bother with; no unlabeled syringes to cause confusion.

2. Inject—with a minimum of pain. Thanks to the single-use, stainless-steel needle that's both ultra-sharpened and siliconized. Aspirate simply and conveniently.

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Wyeth Laboratories Philadelphia, Pa.

Grandpa's Grandpa

W. C. BORNEMEIER, M.D.
Chicago, Ill.

GRANDPA'S GRANDPA was scheduled to die tomorrow, but three members of the family said they positively couldn't get away for his funeral any time soon, so the demise of Grandpa's Grandpa was postponed again, giving him his sixth new lease on life.

He's a very old man now and a lot of grandpas have come and gone in our family in his time. That's why we call him GG for short, to tell him apart from the others.

GG died once, but at the time he was in the hospital having surgery for a hernia. When his failing heart stopped they hooked him up to an artificial heart and restored his life. That was more than 50 years ago, when GG was about 75, and the doctors and nurses who performed that hook-up are now gone.

What with social security, medicare, and his annuity, GG has always had good care and has never really been an invalid. He has had a couple of leg fractures and an occasional bout of asthma or indigestion, but on the whole his health is good, considering his 125 years. He weighs only 90 pounds, so it doesn't cost much to keep him—two small meals a day and a bit of wine. He doesn't smoke and he sits so still that his clothing lasts for years, although it does get somewhat unfashionable.

The consensus seems to be that GG has a good disposition, otherwise the family would have let him die long ago—by just stealing the battery that runs his heart, for instance, or simply failing to replace it with a new one in June, causing a sure summer funeral.

About the time I was born, GG turned 100. That was the year when the family first decided that they should let GG pass away, a decision that, I understand, didn't come easily, but took the best part of an afternoon.

There was considerable opposition to letting GG die, mainly because he was not really in poor health for a man his age. But it was admitted that altho he had a heart in good working order, his brain was badly run down.

By a slim majority, GG was doomed. And then he was resurrected. Someone, who had reached a pretty high station in life by living by the rules, noted that a quorum was not present.

After that first meeting, the subject of GG's funeral didn't come up again for years, possibly because his health seemed to be getting even better, but probably because GG was becoming an asset while his heirs became fewer and fewer.

A small sum of money he had once invested had grown quite large over the years because he used little of the income and the rest just kept accumulating and compounding.

In the summer of his 110th year GG's fate was again discussed at a family meeting. No one mentioned it openly, I've been told, but everyone knew that if GG was allowed to die then, a no-good grandnephew would get a sizeable portion of the estate.

The vote was in favor of keeping GG with us, and a farsighted vote it was because the no-good heir passed on within the year.

With the no-gooder gone, there seemed little reason to prolong the old gentleman's life, so a special session was called. It was noted at the meeting that GG was becoming more forgetful and he sometimes refused to eat. But before the matter came to a vote, a couple of juniors enrolled in premed at one of the universities spoke up and said GG was becoming a valuable research specimen.

The logic of their arguments won over the rest of the family, and GG's funeral was put off for the third time.

At times tho, it almost seemed as if the decision had not been a wise one. During the following winter, GG fell and broke his right leg. Later he fell and broke his left leg. Each time he was hospitalized for six weeks before returning home.

While in the hospital, the artificial prolongation of his life, which everybody agreed was really quite useless, became the subject of widespread debate among doctors, nurses, medical students, and orderlies.

Merely removing the stimulus to the artificial heart could not be considered murder, the argument went. After all, God had created GG with a heart and the heart was still present in the body. If the heart machine were turned off, then it was God's decision whether GG's human heart would function.

A meeting of the clan was called to discuss the wisdom of keeping GG alive, especially in the light of community pressure and gossip. But the family closed ranks—no outsiders were going to tell them what to do with their poor old Grandpa's Grandpa.

The fifth "make-the-decision" session, the first that I've attended, was rather serious because the nature of the problem had changed. A miraculous device had been invented which, if installed, would prolong GG's life indefinitely, possibly for hundreds of years.

Many problems had been created

by the invention of that device, not the least of which was how to justify *not* using the machine. When Grandpa, at age 75, had become the recipient of an artificial heart, his existence had been presented to a future generation, to prolong or end as it thought best.

This new twist to the GG problem completely broke down the decision-making process. No decision was made—as I said before, three members of the family ended the discussion when they said they couldn't make it to a funeral, altho we all knew that they really could.

So GG is 125 today, and I couldn't help thinking during the meeting . . .

The surgeon put a ticker in
To keep our Gramp alive.
But who will turn the gadget off
At a hundred twenty-five?
We often call a problem solved
Because it goes away.
And then we find to our chagrin
The same one's there next day.
But progress is our way of life,
So why should it seem strange.
If the questions must remain the same,
It's the answers that we'll change.

4665 Peterson Ave.
Chicago 60646

(This communication is reprinted with permission from the *Chicago Tribune Magazine*, June 26, 1966 and from *JAMA*, Sept. 26, 1966, Vol. 197, Adv. Page 268. Copyright 1966, by American Medical Association.) ◄

AMA Offers Savings on Smoking Posters

Even the most determined "reformed" smokers slip back to the weed, and even the most aggressive non-smoking campaigns can become equally lax without the infusion of new educational materials. To keep the reformed reformed and the abstainers abstained, the AMA now offers two new anti-smoking posters—"Best Time to Stop Smoking" and "Break the Habit"—in colorful artwork, 18x23", at below-cost prices. Orders should be sent to the AMA Order Department; singles at 20¢, 50-99 at 18¢, 100-499 at 16¢, 500 to 999 at 14¢, and 1,000-up at 12¢. These remarkably low prices are established because the AMA is absorbing distribution and promotion costs to encourage maximum exposure of this important campaign.

These posters are effective in all well-trafficked areas, and with the resumption of the autumn school term, they are recommended for bulletin boards in all schools and colleges.

The Managers of Change

"What, in the end, is management's most fundamental task? It is to deal with change. Management is the gate through which social, political, economic and technological change — indeed, change in every dimension — is rationally and effectively spread through society."—Former Secretary of Defense Robert S. McNamara.

Counterattack on Campuses

"Parents with children in college should encourage them, representing the majority as they do, to democratically oppose and lawfully control the nihilistic, destructive, revolutionary student."—William C. Sullivan, assistant director, Federal Bureau of Investigation.

Where Money is Valueless

"The businessman personally, as a citizen, deplores crime. He often lives and usually works in the city. What does it avail him—or anyone in fact—to build a career and an income if he must live in fear of becoming a crime victim? Money is no good if you live in a jungle."—Richard L. Gelb, president, Bristol-Myers Company.

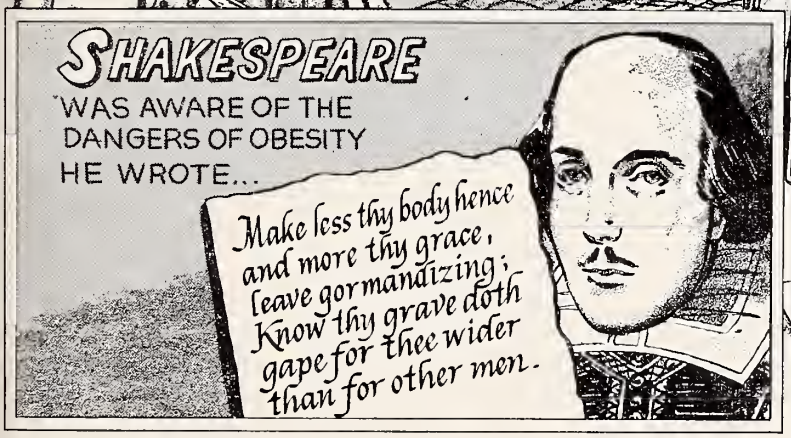
The AMBAR® SCRAPBOOK of Obesity Oddities
FACT & LEGEND

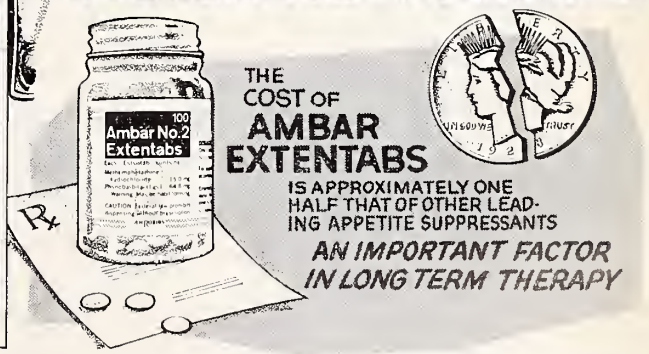
OBESITY WAS A MILITARY OFFENSE!
OVERWEIGHT ROMAN HORSEMEN WERE MADE TO FORFEIT THEIR MOUNTS AND BECOME FOOT SOLDIERS!



RECORDED ON AN ENGLISHMAN'S TOMBSTONE

SHAKESPEARE
WAS AWARE OF THE DANGERS OF OBESITY HE WROTE...





THE COST OF **AMBAR EXTENTABS** IS APPROXIMATELY ONE HALF THAT OF OTHER LEADING APPETITE SUPPRESSANTS

AN IMPORTANT FACTOR IN LONG TERM THERAPY

CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A·H·ROBINS

This is the second of a series of articles on Medicaid about which so much has been written and said, good and bad.

Medicaid in Indiana

*WILLIAM R. STERRETT**
Indianapolis

THE first meeting of the Medical Advisory Committee for Title XIX of the Social Security Act (Medicaid) was held on Wednesday, July 16, 1969 at the State Department of Public Welfare. Such a committee is mandated by Title XIX of the Social Security Act, effective July 1, 1969, and the membership is defined in Chapter 274 of the Acts of 1969. Following are the names of the members who have been duly appointed:

Jack D. Carr, D.D.S., Chairman
Indiana Dental Association (1972)
Indianapolis

George F. Parker, M.D.,
Vice-Chairman
Indiana Chapter, American Academy of Pediatrics (1970)
Indianapolis

Wm. R. Sterrett, Secretary
Ex-officio
Indianapolis

Maurice E. Glock, M.D.
Indiana State Medical Association (1970)
Fort Wayne

Mr. Elton TeKolste
Indiana Hospital Association (1972)
Indianapolis

Robert E. Snodgrass, M.D.
Indiana Psychiatric Association (1970)
Indianapolis

Albert F. Kull, D.O.
Indiana Association of Osteopathic Physicians and Surgeons (1970)
South Bend

Mrs. Mary K. Conduitt
Indiana State Nurses Association (1972)
Evansville

Mrs. Eloise Wilson
Indiana State Licensed Practical Nurses Association (1972)
Evansville

Dr. Jack B. Glick
Indiana State Podiatry Association (1972)
Indianapolis

Mr. Kenneth G. Crowel
Indiana Association of Licensed Nursing Homes (1972)
Knox

Raymond C. McDonald, O.D.
Indiana Optometric Association (1971)
Frankfort

Mr. James D. Hawkins
Indiana Pharmaceutical Association (1971)
Indianapolis

Jack W. Main, D.C.
Indiana State Chiropractic Association (1972)
Indianapolis

Mr. Eugene L. Kezy
Appointed by the Governor to represent the citizenry of Indiana (1971)
Gary

Mr. Harold Hertweck
Appointed by the Governor to represent the citizenry of Indiana (1971)
Indianapolis

Hon. Gene E. Snowden
Indiana State Senate (1971)
Huntington

Hon. Herbert E. Williams
Indiana House of Representatives (1971)
Kokomo

Louis W. Spolyar, M.D.
Ex-officio — Representing the State Health Commissioner
Indianapolis

Mr. James B. Richman
Ex-officio — Representing the Mental Health Commissioner
Indianapolis

Jack D. Carr, D.D.S., was elected chairman and George F. Parker, M.D., vice-chairman as the first order of business at the meeting. Mr. Sterrett, Administrator of the State Department of Public Welfare, explained the program of medical as-

* Administrator, State Department of Public Welfare, 100 N. Senate Ave., Indianapolis 46204.

sistance as it has functioned since 1942 in Indiana, pointing out that the relationship with the medical profession during this period has been both cooperative and pleasant. He added that this experience gives Indiana an advantage over many other states where costs have been astronomical under Title XIX because of lack of experience. Mr. Sterrett said Indiana is going into this new program slowly, providing all medical services but limiting them to those persons who are categorically eligible for public assistance; i.e., indigent and past 65, blind, disabled and families with dependent children. The need for quality care at the lowest possible cost was stressed.

Representatives of Blue Cross-Blue Shield, the carrier for Title XVIII (Medicare) in Indiana, explained the function of such an intermediary under Title XIX, stating that they have the responsibility for paying promptly and efficiently for authorized medical services provided to eligible persons. The State Department of Public Welfare is the single state agency responsible for administration of Title XIX with authorization to contract for payment.

Mr. Robert O. Brown, Director of the Division of Public Assistance of the State Department of Public Welfare, explained that many organizations, associations, and agencies, both public and private, would be working with the State Department of Public Welfare in the implementation of Title XIX, specifically the State Board of Health, the Department of Mental Health and Social Security. It was pointed out that a new trend is developing whereby government and the private sector work cooperatively to develop programs.

The meeting was well attended and the members participated freely, asking questions concerning delays in payment, limitations on fees, and problems with verifying eligibility.

Wednesday, September 3, 1969, was set as the date of the next meeting, although the committee is required to meet only four times a year. ◄

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A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, music therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available

Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.

Assistant Professor of Psychiatry and Medical Director

Area Code 704-254-3201

Symbols in a life of psychic tension

M.A.

class of '66

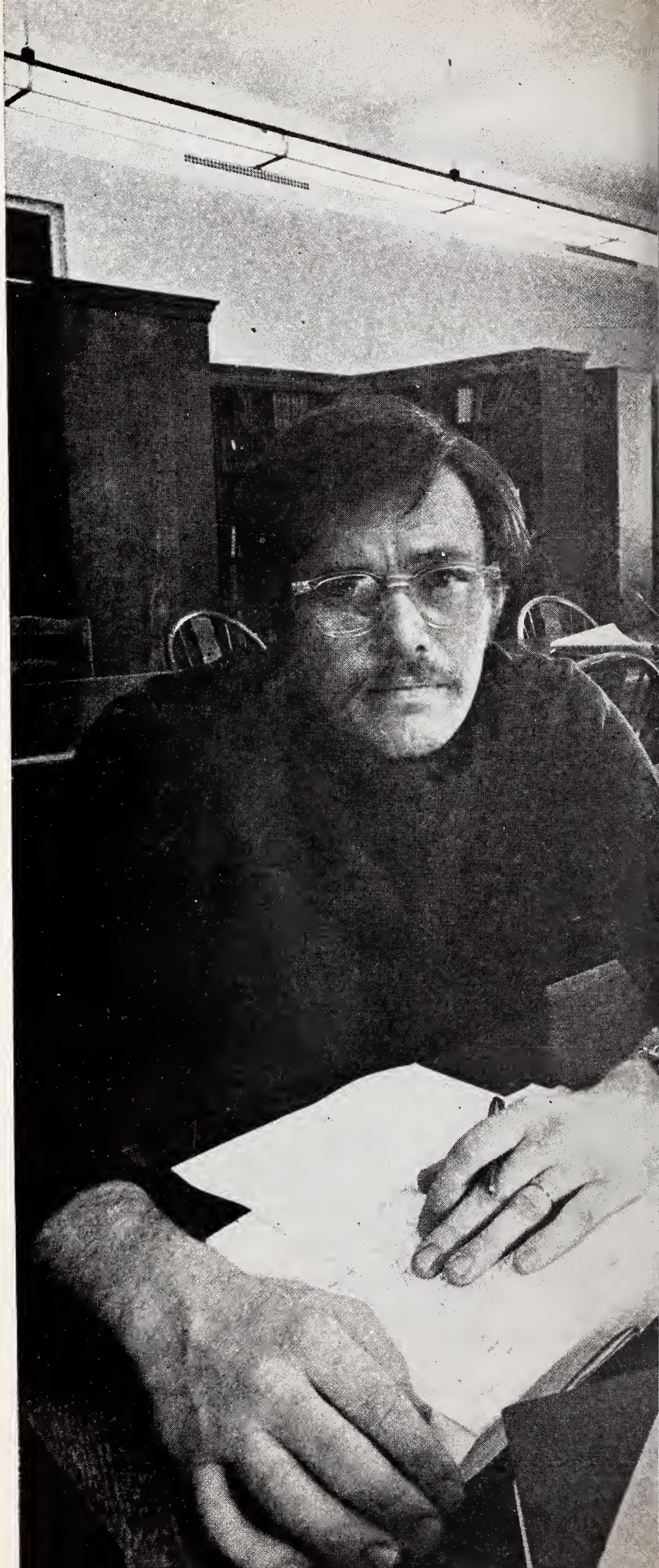
Ph.D.

thesis...in progress

G.I.

series and complete examination normal

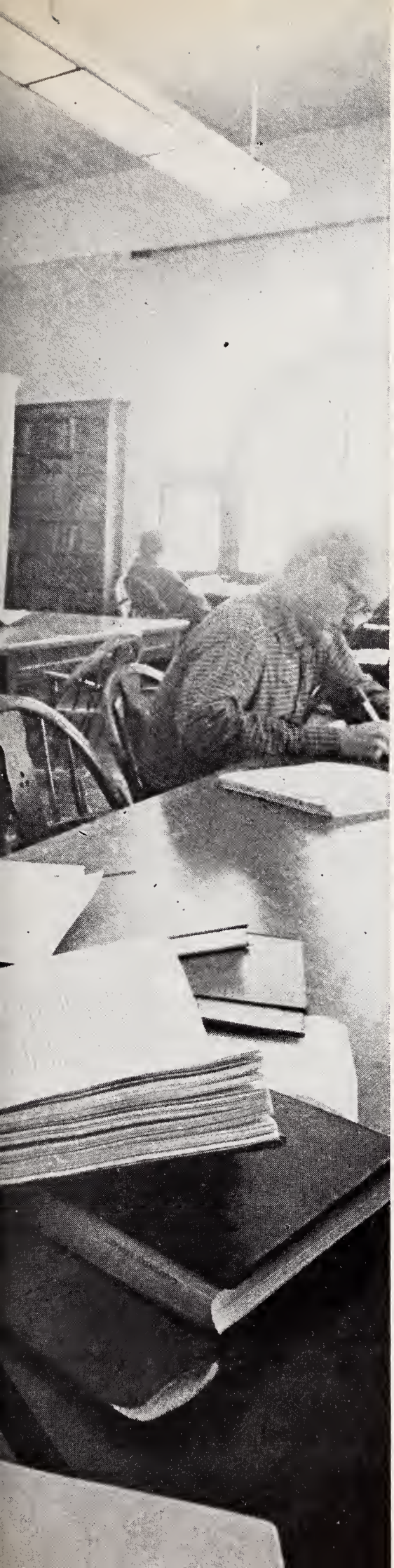
(persistent indigestion)



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Nutley, New Jersey 07110



Rx

Valium® (diazepam) *t.i.d.* and *h.s.*

M. A. (class of '66)... Ph.D. (thesis, in progress)... letters that represent a young lifetime of work... a formal education nearing completion. But there are still long, arduous examinations to pass, a doctoral thesis to finish... a period in which stress is often converted into the gastrointestinal symptoms of psychic tension. For this kind of patient—with no demonstrable pathology—consider the usefulness of Valium (diazepam).

Valium can help relieve psychic tension and resultant somatic symptoms, within the first day for some patients. Valium is also useful in psychic tension with associated depressive symptoms. And Valium can help relieve psychic tension-induced insomnia with an *h.s.* dose added to the *t.i.d.* schedule.

Valium is generally well tolerated. In proper maintenance dosage it seldom dulls the senses or interferes with functioning. Side effects most commonly reported have been drowsiness, fatigue and ataxia.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

to help relieve psychic tension
and its somatic symptoms

Blue Cross and Blue Shield "Best Buy" in Health Coverage

(One of a series prepared by Blue Shield)

The U. S. Government has just released a comprehensive report showing once again that Blue Cross and Blue Shield Plans offer a better value for health insurance coverage than commercial insurance companies.

The 19-page report appears in the February, 1969 issue of *Social Security Bulletin*, published by the Department of Health, Education & Welfare. Among the highlights of its findings are the following facts.

During 1967 Blue Cross and Blue Shield Plans paid back in benefits about *90%* of their premium income during the period studied, compared to less than 83% returned by commercial insurance companies.

The Blue Cross and Blue Shield Plans operating expenses (for hospitalization and surgical/medical contracts) averaged less than 7% of income, including both group and individual contracts, while insurance company expenses averaged 21.4% of overall income—13.1% of group premiums and 43.7% of individual members' premiums. Indiana Blue Cross and Blue Shield operating expenses for the year averaged 6.4% of income.

Looking at operating costs from another, more significant viewpoint, the government statisticians reported that the Blue Cross and Blue Shield Plans spent an average of about *8¢* in administrative costs to pay out $1 in benefits. By comparison, it cost insurance companies 14¢ to pay $1 in benefits on group policies, and 83¢ in administrative costs to pay $1 in benefits for individual policyholders. Indiana Blue Cross and Blue Shield spent 7.2¢ in administrative costs to pay out $1 in benefits during the period studied.

Even though insurance companies' administrative costs were demonstrated to be much higher than Blue Cross and Blue Shield expenses, the report commented that:

"The administrative expenses of these [Blue Cross and Blue Shield] Plans reflect the total cost of administration, but a large part of claims administration under many group policies of insurance companies is performed by the insured company or group and is not reflected in the insurance company's operating expenses."

Finally, the report noted that while the Blue Cross and Blue Shield Plans earned only 41% of all the premiums for health care coverage paid to all carriers during the period, they paid out 43% of all benefits and accounted for less than 20% of all operating expenses. On the other hand, insurance companies earned 53% of total premiums paid to all carriers and paid out only 51% of benefits, while they accounted for 77% of all operating costs.

The facts are clear. Blue Cross and Blue Shield Plans still represent the better value for health coverage, both through groups and individual contracts. The Blue Cross and Blue Shield Plans pay more benefits per dollar, and retain less in operating expenses. ◄

Source:

Social Security Bulletin, February, 1969, Volume 32, Number 2, published by U. S. Department of Health, Education & Welfare, Social Security Administration. (Data in parentheses furnished by Indiana Blue Cross and Blue Shield.)

Benadryl®
(diphenhydramine hydrochloride)
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Parke, Davis & Company, Detroit, Michigan 48232
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now he can cope...



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Butisol SODIUM®
(SODIUM BUTABARBITAL)

the "daytime sedative" for everyday situational stress

When stress is situational—environmental pressure, worry over illness—the treatment often calls for an anxiety-allaying agent which has a prompt and predictable calming action and is remarkably well tolerated. BUTISOL SODIUM (sodium butabarbital) meets this therapeutic need.

After 30 years of clinical use . . . still a first choice among many physicians for dependability, safety and economy in mild to moderate anxiety.

Contraindications: Porphyria or sensitivity to barbiturates.

Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression.

Adverse Reactions: Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.

Warning: May be habit forming.

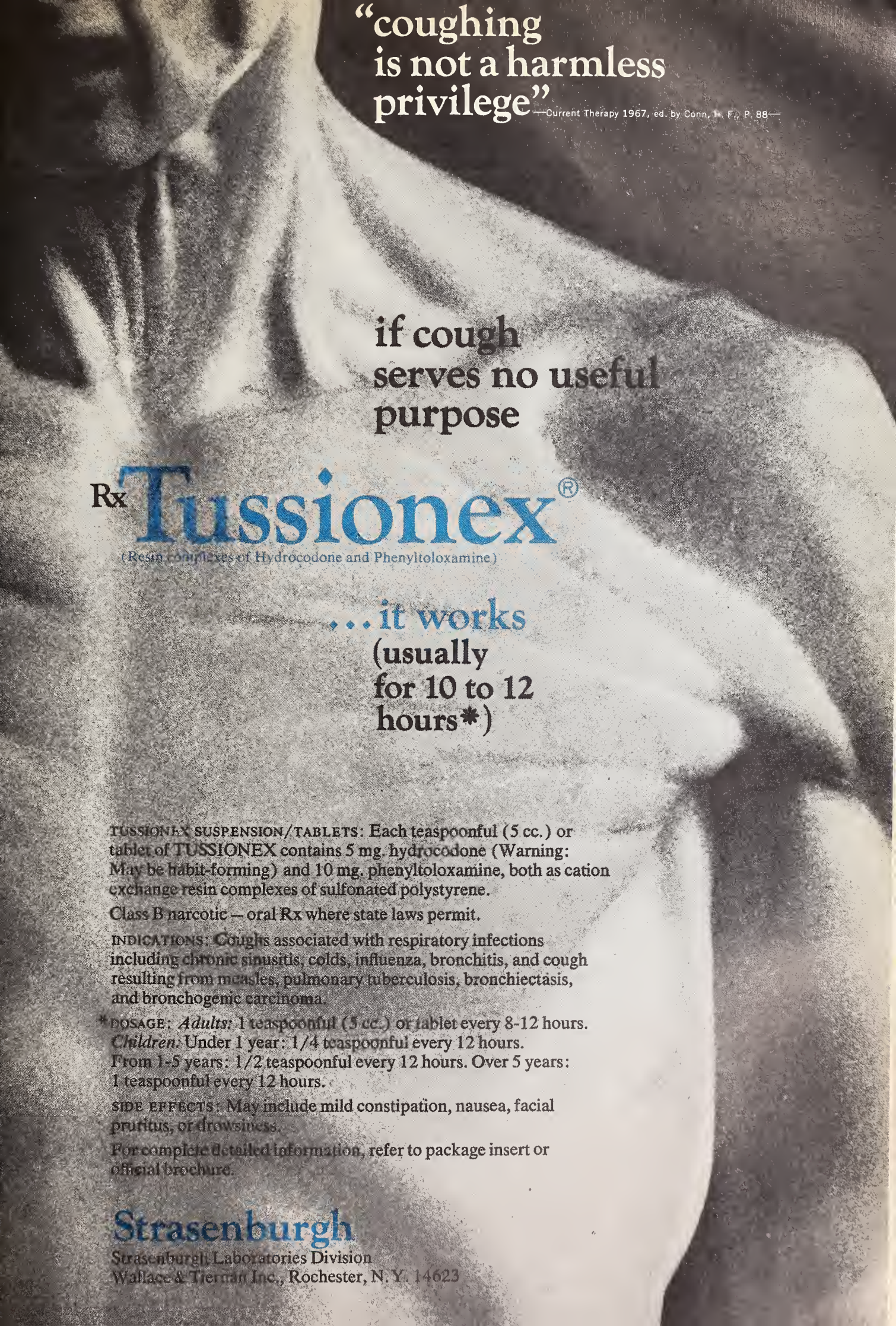
Usual Adult Dosage: As a daytime sedative, 15 mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

Available for daytime sedation: Tablets, 15 mg. (¼ gr.), 30 mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg. (¼ gr.), 30 mg. (½ gr.).

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TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.

Class B narcotic – oral Rx where state laws permit.

INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

For complete detailed information, refer to package insert or official brochure.

Strasenburgh

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No place for beginners

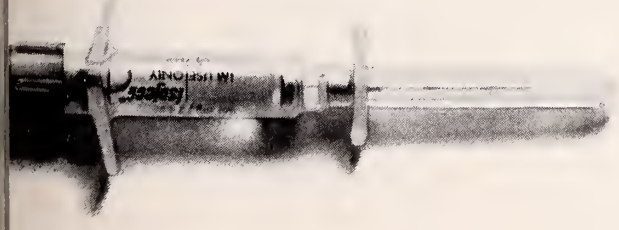
Terramycin®
oxytetracycline)

Fire victim. Examination reveals second degree burn of lower leg. To combat shock, restore circulatory volume and replace protein loss, plasma is administered. Local pressure dressing applied. Limb elevated to limit the flow of lymph. About 36 hours after admission the patient develops an elevated temperature and complains of pain at the site of the lesion. Dressing removed. A suppurating slough area has developed over part of the burn. A swab specimen is taken for culture and the slough area is debrided. Antibacterial treatment is begun with Terramycin I.M. Days later, recovery is progressing, and the laboratory report shows a mixed infection with a predominance of susceptible coliform bacteria, confirming the therapeutic choice. Terramycin therapy is continued until all signs of infection disappear.

Experience has shown that Terramycin offers special advantages in treating bacterial infections complicating burns, when strains of causative organisms are susceptible. Broad-spectrum antibacterial coverage. Activity unaffected by penicillinase. Rapidly achieved therapeutic blood levels. Proven tissue toleration.

Terramycin I.M. is the only preconstituted broad-spectrum antibiotic designed specifically for intramuscular use. Requires no refrigeration. Remains stable for at least two years. Available for immediate use in Isoject,® a disposable injection unit. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Terramycin® I.M.
(oxytetracycline)



Pfizer **LABORATORIES DIVISION**
New York, N.Y. 10017

Contraindicated: In individuals hypersensitive to any of the components of this drug.
Warnings: If renal impairment exists, even usual doses may lead to excessive systemic accumulation and possible liver toxicity. In such patients, lower than usual doses are indicated and for prolonged therapy oxytetracycline serum level determinations may be advisable.
Terramycin may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.
Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.
During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight. Discontinue therapy at first evidence of skin discomfort.
Note: With oxytetracycline, phototoxicity is not believed to occur and photoallergy is very rare.
Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy.
As with all intramuscular preparations, Terramycin Intramuscular Solution should be injected well within the body of a relatively large muscle. *Adults:* The preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. *Children:* It is recommended that intramuscular injections be given preferably in the mid-lateral muscles of the thigh. In infants and small children the periphery of the upper outer quadrant of the gluteal region should be used only when necessary, such as in burn patients, in order to minimize the possibility of damage to the sciatic nerve.
The deltoid area should be used only if well developed such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.
Increased intracranial pressure with bulging fontanelles has been observed occasionally in infants receiving therapeutic doses of the drug, but such signs and symptoms have disappeared rapidly on cessation of treatment with no sequelae.
Adverse Reactions: Subcutaneous and fat-layer injection may produce mild pain and induration which may be relieved by an ice pack. Very mild gastrointestinal disturbances, not requiring discontinuance of the drug, may occur occasionally. Allergic reactions, including anaphylaxis, rarely have been observed.
Dosage: *Adult:* The optimal dosage varies, depending on the type and severity of infection. Unless otherwise specified, a dose of 100 mg. every 8 to 12 hours, or a single daily dose of 250 mg. should be adequate for the treatment of most mild or moderately severe infections. In severe infections, 100 mg. every 6 to 8 hours, or 250 mg. every 12 hours may be necessary.
Serum levels obtained by the recommended dosages are comparable to those provided by the oral dosage of 1 to 2 Gm. daily in adults. Antibiotic therapy should be continued for at least 24 to 48 hours after all symptoms and fever have subsided.
In certain diseases specific courses of therapy may be recommended as a general guide. In primary and secondary syphilis for example, the daily administration of 2 Gm. oxytetracycline, orally, in divided doses for two weeks has given good results. In cases of gonococcal infection two intramuscular injections of 250 mg. each, or one intramuscular injection of 250 mg. combined with one gram given orally as a single dose, will usually suffice, but repetition of this therapy will be required in an occasional case.
In the treatment of hemolytic streptococcal infections, therapy should continue for at least 10 days to prevent development of rheumatic fever or glomerulonephritis.
In the treatment of staphylococcal infections indicated surgical procedures should be carried out in all cases.
Pediatric: A dosage of 3 mg./lb./day in two doses has been found satisfactory in the treatment of most mild to moderately severe infections. For more severe infections, higher dosages may be indicated and should be adjusted accordingly.
Terramycin Intramuscular Solution provides maximum absorption and patient toleration with minimal local irritation.
Supply: Terramycin (oxytetracycline) Intramuscular Solution: available in single dose, prescored glass ampules containing 100 or 250 mg. oxytetracycline/2 cc., Isoject® syringes containing 100 or 250 mg. oxytetracycline/2 cc. and 10 cc. multiple dose vials containing 50 mg. oxytetracycline/cc.
More detailed professional information available on request.



GLEANED FROM THE BRITISH MEDICAL JOURNAL

JACK W. HICKMAN, M.D.
Indianapolis

Fetal Distress and Heart Rate

One of the first assigned chores for junior students on their obstetrical clerkship is still to learn to count the fetal heart rate. They are taught that this is important so that fetal distress can be detected. Finally some investigators decided to see if this determination was really accurate and if it was of any real value.

Day, Maddern and Wood compared clinical evaluation of fetal heart rate with rates determined by electronic monitoring in 144 patients.[1] It was found that house staff findings were in error of ± 15 beats per minute in 20% of their patients. Furthermore the error was often a "biased" one, i.e., low rates were estimated to be higher and high rates were estimated to be lower.

The authors however concluded that despite these errors in observation, a clinically observed fetal heart rate of more than 160 beats per minute was found to be associated with a significantly lower Apgar score at birth. Heart rates that remained fairly stable in the 120-160 beats per minute range were not associated with low Apgar scores. It looks as if the juniors will continue to count.

Home Care for Coronaries

It is always somewhat reassuring to see a nicely written, valuable paper published in a "prestige" medical journal by a general practitioner using his own clinical experience as the basis for the paper. The report of Sleet[2] that concerns home treatment of 24 patients with myocardial infarction is such a paper. Of the 24 patients only two died; one from a pulmonary embolus and one from an arrhythmia. The patients were seen in only a four-year-period. The age distribution of the patients and the frequency of other conditions, e.g., diabetes mellitus, hypertension, seem to compare roughly with the patients with whom we are all familiar. Anticoagulant therapy was not given, but patients were encouraged to use a bedside commode and a "bedside-chair" program was the generally used method. These statistics are quite respectable and should remind us that such management methods can be acceptable for patients who do not care to be removed from their home environment.

The ST-T Wave and Hypertension

"Non-specific ST-T wave changes" is a phrase with which we are all familiar, and is frustrating to most of us. A small study of 17 patients by Hamer et al. attempts to provide further help in learning the significance of these changes.[3] Their study reports that S-T segment depression and T wave depression distinguishes patients with higher systolic blood pressures from normals. Actually all 17 patients were hypertensive but half the group was sicker than the other half. The ST-T wave changes were found in the sicker group. No wave changes were found in the sicker group. No normals were in the study, nor were patients with arteriosclerotic heart disease nor any patients who were receiving digitalis. The diastolic blood pressures were higher in the sick group. Actually this study seems to show that bad hypertension gives worse ECG's than mild hypertension. Time will tell.

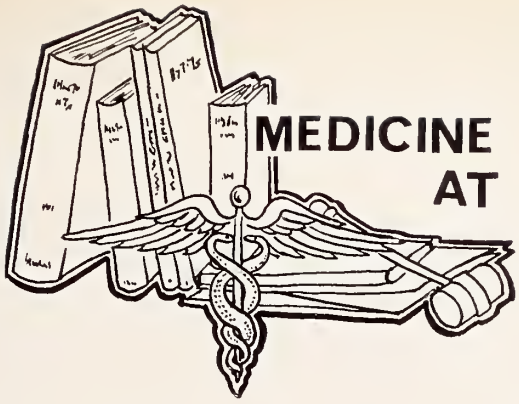
* * *

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2. Sleet, R. A.: Report of 24 Cases of Myocardial Infarction Treated at Home, *Brit. Med. J.* 4:675-677, No. 5632.

3. Hamer, J., Shinebourne, E., Fleming, J.: Significance of Electrocardiographic Changes in Hypertension, *Brit. Med. J.* 1:79-82, No. 5636. ◄



Examining Physician not Compelled to Testify—In a workmen's compensation proceeding, a trial court properly refused to compel a physician to testify as to the results of an examination made of the claimant at the request of the social security administration to enable it to pass on the claimant's claim for social security benefits, a Texas appellate court ruled. The examination was privileged under the federal statute and regulations.

The statute and regulations prohibit the disclosure of any information obtained by any person with whom the social service administration has entered into an agreement to perform functions which in any way relate to or are necessary to or are used in connection with the administration of disability or health insurance programs.

In view of the statute and regulations, the physician could not be compelled to testify about the examination of the claimant which he made at the request of the social security administration to assist it in evaluating his claim for financial aid under the social security act. If he had disclosed information about the examination and his report to the social security administration he would, under the provisions of the statute, have been subject to criminal prosecution.

The contention that the statute and regulations did not apply because the physician was attempting to assert a private privilege, rather than that of the Secretary of Health, Education and Welfare, was rejected. The Secretary appeared through his attorney and moved to quash the subpoena for the physician and his report on the ground that his information was privileged under the statute and the regulations.—*Texas Employers' Insurance Association v. Marshall*, 436 S.W.2d 617 (Tex., Jan. 10, 1969; rehearing denied, Jan. 31, 1969).

Physician's Good Will is Community Property—In a divorce action between a physician and his wife, a trial court properly took into account, in determining the community property award to the wife, the good will of the physician's practice, a California appellate court ruled. The good will of the practice was a community asset.

The physician was a sole practitioner. The trial court assigned a value of $32,500 to the good will of his practice and included it as an asset of the community.

The physician's practice as a sole practitioner will continue to have the same intangible value that it had during the marriage. Under the principles of community property law, the wife, by virtue of her position of wife, made the same contribution to that value that a wife makes to any of the husband's earnings and accumulations during the marriage. She was as much entitled to be recompensed for that contribution as if it were represented by the increased value of a stock in a family business. —*Golden v. Golden*, 75 Cal. Rptr. 735 (Cal., March 5, 1969; rehearing denied, March 19, 1969).

Presumption of Negligence in Vein Surgery Suit—A verdict was improperly directed for a physician in a suit by a patient who suffered injury to the common peroneal nerve during surgery for the removal of the lesser saphenous vein of his left leg, a California appellate court ruled. The case should have been submitted to the jury under a conditional *res ipsa loquitur* instruction.

The physician used a Linton stripper in performing the operation. He was uncertain whether he pulled the stripper out through the popliteal incision or the malleolus incision. Either method is medically acceptable. However, when the vein is pulled through the popliteal space, the vein, which gathers in bunches at the head of the stripper, must be drawn through tissues in the vicinity of the common peroneal nerve.

After the operation the physician wrapped the leg with an ace elastic bandage. It was loosened later that day when the patient complained of numbness in his leg.

Tests performed shortly after the patient's discharge disclosed that he had difficulty in dorsiflexing his foot, indicating nerve impairment of the leg. The physician ordered physical therapy treatment to preserve muscle tone while the nerve was regenerated. Despite the treatments the patient developed a partial foot drop. The physician concluded that the patient had an impairment of the common peroneal nerve. The physician treated the patient for more than a year after the operation. No charge was made for the treatment.

The patient continued to suffer pain in his left foot after the physician discharged him. He consulted a neurosurgeon and a vascular surgeon, both of whom diagnosed his condition as causalgia caused by injury to the common peroneal nerve. A lumbar sympathectomy was per-

Continued

formed to relieve the symptoms.

The vascular surgeon testified as to the relationship between the lesser saphenous vein and the common peroneal nerve. He stated that, with an incision of the size that was made in this case, vigorous use of retractors would have been required. He said that, although there are some risks of nerve injury in vein stripping, there are recognized techniques for its avoidance. In his performance of 1,000 similar operations, he had never encountered any impairment of the common peroneal nerve and had never heard of such a result stemming from the operation.

The neurosurgeon testified that common peroneal nerve injury would be possible, but unlikely, if the operation were performed with the usual care. He stated the opinion that the more probable cause of the injury was overtight bandaging.

The physician, who was called as an adverse witness, testified that the nerve impairment might have been caused by "bruising" in the course of surgery, due to the mass of venous tissue accumulated on the stripper. He admitted that "bruising" of the nerve could be avoided by the observance of proper surgical precautions.

There was evidence that peroneal nerve injury in a vein stripping operation was extremely rare. The evidence of extreme rarity, combined with the following additional evidence, was sufficient to entitle the patient to have the case submitted to the jury under a conditional *res ipsa loquitur* instruction: the operation was relatively commonplace, rather than complex or unusual; the physician made no mention of risk of nerve injury when he recommended surgery; expert testimony that the injury would have been unlikely if the operation had been performed with due care; expert testimony that the size of the incision would have required vigorous use of retractors in the proximity of the peroneal nerve; expert testimony that overtight bandaging was the probable cause of the injury; the physician's admission that the nerve was "bruised" during the operation and that "bruising" can be avoided by using proper surgical precautions; the physician's furnishing of extensive postoperative and physical therapy treatments to the patient without charge. This evidence was sufficient to permit the drawing by a jury of an inference of negligence from the fact of the accident.

The physician contended that the expert testimony that nerve injury can be avoided by proper surgical precautions was insufficient to show probability of negligence, because such proper precautions were never described and there was no evidence that he failed to take them. In order for *res ipsa loquitur* to apply, it is not necessary that the evidence show that the actual procedure followed by the physician was negligent. It is enough if the evidence supports an inference of negligence from the fact that the injury occurred.

The physician's contention that *res ipsa loquitur* was not applicable, because the evidence failed to establish that the accident was caused by an instrumentality within his exclusive control, was without merit. There was substantial evidence that in all probability the injury occurred during the operation and that the operation was under the physician's control. If it is the physician's contention that someone else caused the injury, he has the burden of proving that contention.—*Frazer v. Sprague*, 76 Cal. Rptr. 37 (Cal., March 18, 1969).

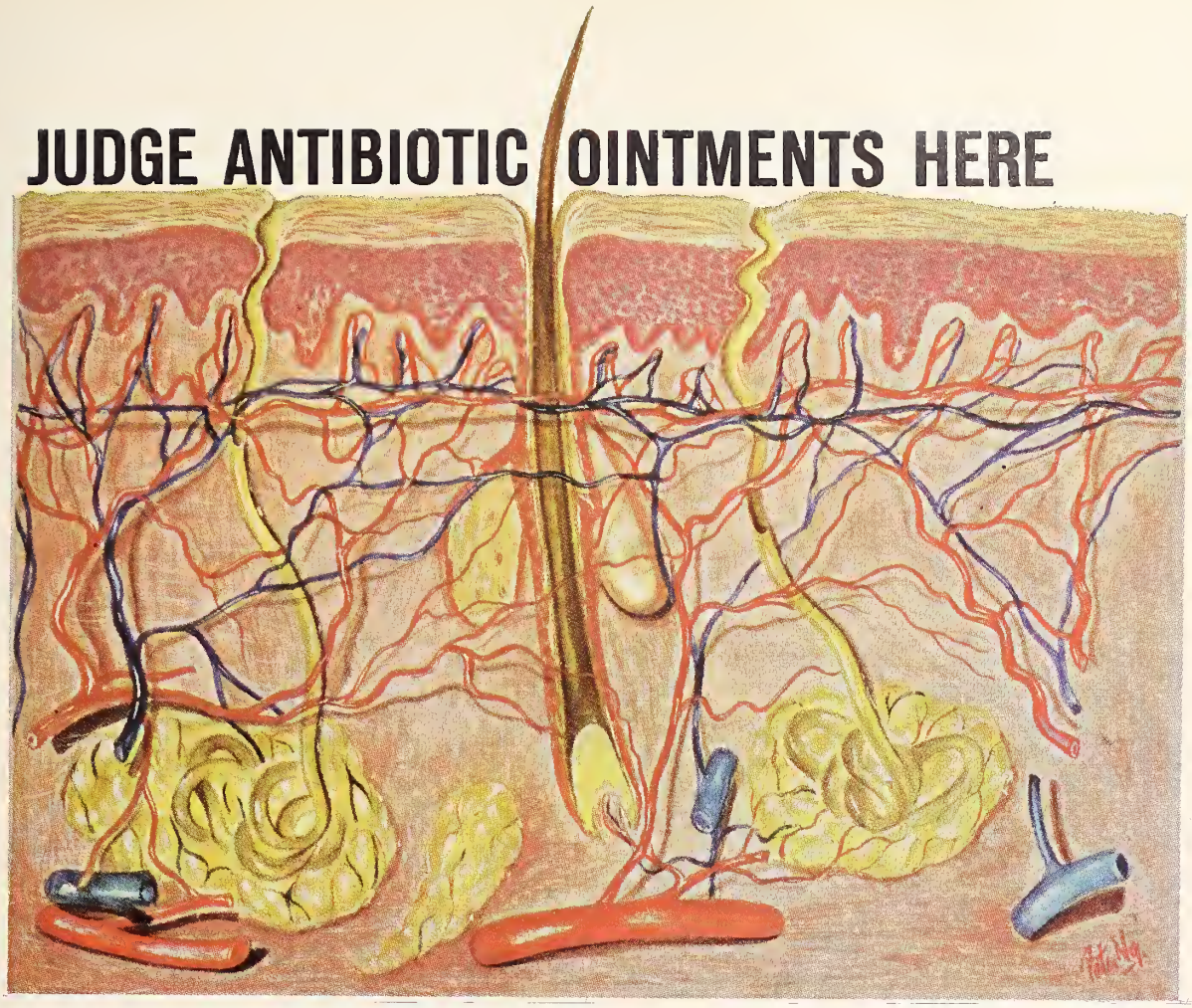
Medical Society Ordered to Reinstate Physician—A county medical society violated a physician's right to due process when without according him a hearing, it dropped him from its membership rolls, an Ohio appellate court ruled. The society was ordered to reinstate him on the membership rolls, with all of the rights and privileges of membership.

The society admitted the physician to membership in 1947. In 1955, he was granted "on leave" status when he undertook a residency in psychiatry in a state mental hospital in another county. After completing the residency, he joined the hospital's staff.

When the society learned that he had joined the hospital's staff, it removed his name from the membership rolls on the ground that he was not, as was required by the society's bylaws, either residing or practicing in the county. He was not given prior notice of the society's action or accorded a hearing on the matter. The society's bylaws make no provision for such an automatic loss of membership.

Society membership is a valuable right which may not summarily be taken away. Since the society's bylaws did not make provision for expulsion on the grounds involved here, the law will write into the bylaws a requirement for an opportunity to be heard. Since the physician was not accorded an opportunity to be heard, the society's action in dropping him from the membership rolls was a nullity.—*Milkie v. Academy of Medicine*, 246 N.E.2d 598 (Ohio, April 9, 1969). ◄

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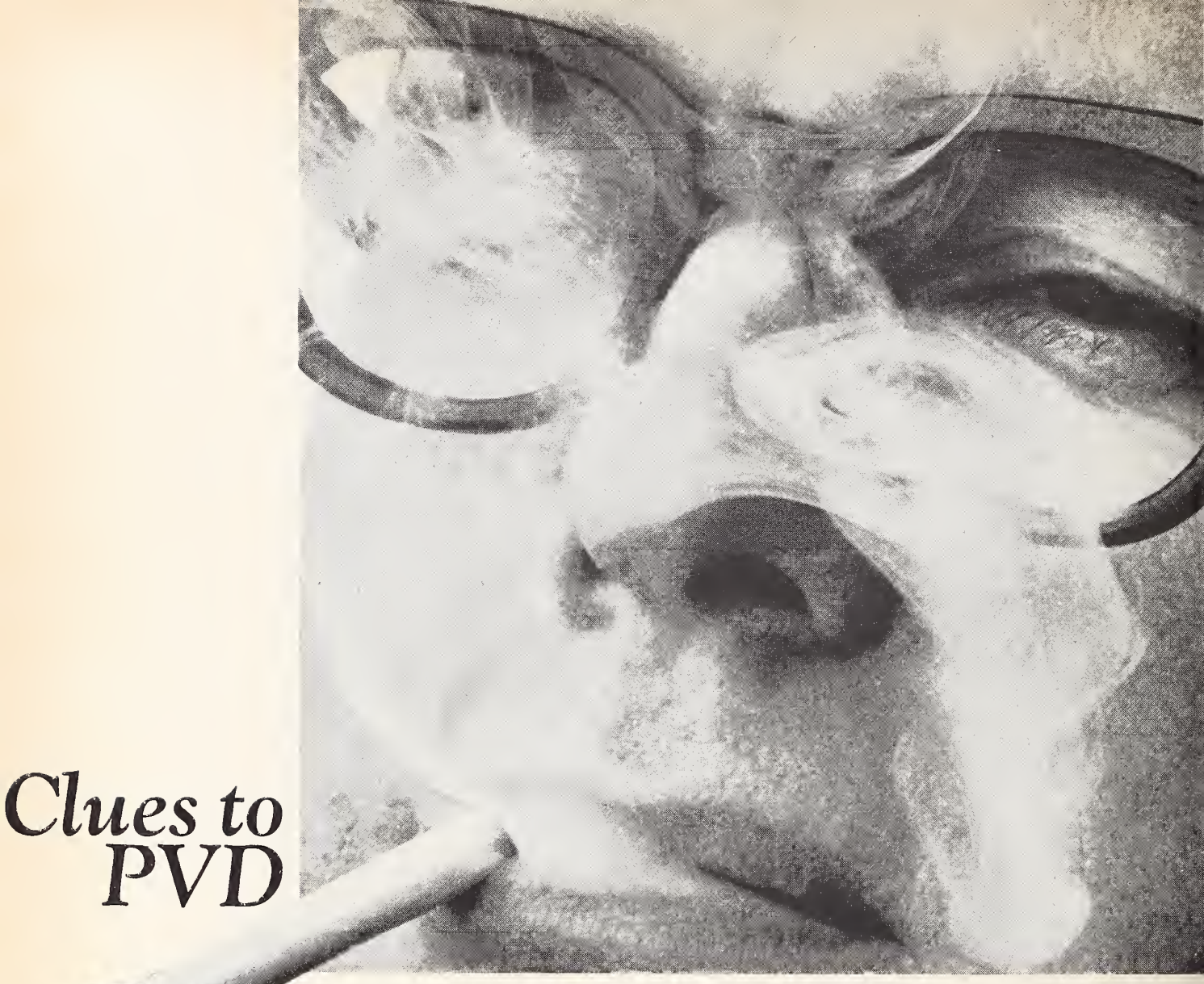
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Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

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ABSTRACTS, BOOK REVIEWS

HOW TO LIVE WITH HYPOGLYCEMIA

Charles Weller, M.D., Brian Richard Boylan, Doubleday and Company, Inc., Garden City, New York, 1968; 130 pages; $4.50.

The best situation for a physician, according to the old story, is to discover a disease which only he can diagnose and treat. *Hypoglycemia* is about a disease anyone can diagnose and everyone can treat. Hypoglycemia is allegedly the "in" disease now. Small wonder; it is scarcely separable from many functional, iatrogenic and social conditions of which anxiety is a part. Diagnosis is made through the glucose tolerance test which shows an abnormal dip in the third or fourth hour.

So if you have fatigue, nervousness, drowsiness, sharp hunger, trembling, sweating, rapid heartbeat, dizziness, or headaches, you may have hypoglycemia! Eat more proteins.

I haven't seen many patients with abnormal depth in their glucose tolerance curves; perhaps Dr. Weller is more aware.

Your patient may be asking you about this book.

ALVIN J. HALEY, M.D.
Fort Wayne

ADRENERGIC NEURO-TRANSMISSION

Ciba Foundation Study Group #33, edited by G. E. Wolstenholme and Maeve O'Connor, Little, Brown & Co., Boston, Mass., 1968; 123 pages; $4.50.

This is an edited transcript of a roundtable discussion by some two dozen experts in the stated field; the chair was held by Sir Lindor Brown. We have, indeed, come a long way from the days of the "Immanent Mind." Nevertheless, sober consideration of "long-term" and "short-term" memory—of membrane potentials—even of adrenergic neuro-transmission—all this is a multisyllabic facade masking our true ignorance of just what constitutes the hysteresis phenomena that combine to be our total being, MIND.

We are just realizing that acetylcholine is the usual chemical present at synapse to transmit the impulse forward. The mammal may be the avant garde of life-employing noradrenaline! Very interesting; why? We don't really know.

Why should smooth muscles, collagen fibers and nerve varicosities differ so fundamentally? Again: we don't have the faintest!

But: we have reached the stage of measuring structures in um. diameter; we can trace the catecholamines with some certainty from tryptophan to noradrenaline. I'm jealous of the generation gap; the students of today will be giving the firm replies of tomorrow.

In the meantime, the volume is very inexpensive; the binding and printing are fine and: the book is an interim report by abstruse experts to their peers in that area of neuro-biochemistry.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

WILLIAM HENRY WELCH AND THE HEROIC AGE OF AMERICAN MEDICINE

Flexner, Simon and Flexner, James, Dover Publications, Inc., New York City, 1969.

This attractive reprint of a work published in 1940 should hold enormous interest for those (like the reviewer) who have never studied American medical developments of the latter 19th and early 20th centuries. Certainly, William Henry Welch, M.D., was a giant in this heroic age of American medicine. He founded the country's first pathologic laboratory in 1878. Called to Baltimore, he launched the Johns Hopkins Medical School on its epic course and introduced innovations that later became the universal standard. Throughout his life, he was to enlist the resources of American philanthropists in the support of scientific medicine.

Author Simon Flexner was one of William Henry Welch's colleagues at Johns Hopkins. His co-author, son James, wrote the intriguing *Doctors on Horseback* in 1937. A plastic-covered paperback, *William Henry Welch and the Heroic Age of American Medicine* is a bargain at $3.00.

W. D. SNIVELY, JR., M.D.
Evansville

APPRAISAL OF CURRENT CONCEPTS IN ANESTHESIOLOGY

John Adriani, M.D., editor, with 25 contributors, C. V. Mosby & Co., St. Louis, 1968; 464 pages; $12.00.

This is the fourth volume in a series started in 1961, and it is devoted to a well digested scanning of the timely literature in many fields, primarily, but not by any means limited to the interests of anesthesiologists.

In a preface the editor tells the story of how the series was started as the result of the efforts of the staff members and the residents to divide the literature in their fields of interest and condense it into more or less capsule form for the use of the department of anesthesiology at Charity Hospital in New Orleans. It is apparent that this is not simply the product of a "journal club," but a much more comprehensive reviewing of subjects of interest, including the literature and pertinent observations of modern concepts, as found in current and recent journals, monographs and related more distant references. It was apparent that this condensed and coordinated information deserved wider use than that of the one audience, and so the series was born.

It might seem to some that a book of this sort might have little to offer to the general medical reader, but this is not so. Doctor Adriani points out that in recent years, anesthesiology has broadened its scope to encompass many subjects, such as the pharmacology of adjunctive anesthetic drugs, the hazards of drug interactions, and various phases of physiology that are of practical importance to the anesthesiologist. However, as one scans the 50 articles in this book, it is obvious that there is meat for every type of appetite.

For the serious student the short articles, averaging about eight or nine pages each, are a means of being introduced to the various subjects, and if the matter is of greater interest, the very comprehensive bibliographies will lead further into the subject.

Another very practical appeal of this volume is its small size and clean readable format. It would seem to be an ideal book for the bedside table, or the easy chair by the fireplace.

LALL G. MONTGOMERY, M.D.
Muncie

Abstracts From Various Literature, Prepared by AMA

COMBINATION CHEMOTHERAPY USING CYCLOPHOSPHAMIDE, VINCRISTINE, METHOTREXATE, AND 5-FLUOROURACIL IN SOLID TUMORS

J. J. Costanzi (Wilford Hall, USAF Hospital, Lackland Air Force Base, Tex.) and C. A. Coltman, Jr.

Cancer 23:589-596, (March), 1969.

Combination therapeutic regimen consisting of cyclophosphamide, vincristine, methotrexate, and 5-flourouracil for disseminated solid tumors in 31 patients resulted in objective response in 16. Particularly responsive were malignant melanoma, pancreatic adenocarcinoma, and certain mesenchymal sarcomas. Two patients achieved a complete remission after three courses of therapy. One with synovial sarcoma is alive at 27+ months, and the other with melanoma is alive at 11.0+ months. Toxicity was noted in 25 patients with 13 noting moderate toxicity.

SUBACUTE SCLEROSING PANENCEPHALITIS: PROPAGATION OF MEASLES VIRUS FROM BRAIN BIOPSY IN TISSUE CULTURE

T. T. Chen et al. (Indiana University Medical Center, Indianapolis)

Science 163:1193-1194, (March 14), 1969.

Syncytial cells were rendered fluorescent with measles-specific antiserums in monolayer cultures established from brain tissue of a patient with subacute sclerosing panencephalitis. The ultrastructural appearance of the microtubular aggregates was identical in brain tissue and in the cultured cells. Fusion experiments produced a cytopathic effect in human embryonic kidney and VERO cell cultures.

"EMPHYSEMA PROFILE" IN TWO MIDWESTERN CITIES IN NORTH AMERICA

S. Ishikawa et al. (University of Manitoba, Winnipeg)

Arch. Environ. Health 18:660-666, (April), 1969.

Morphological analysis of 600 lungs from the heavily industrialized city of St. Louis and the prairie agricultural city of Winnipeg, indicated that in St. Louis emphysema is more prevalent, destruction occurs earlier and progresses more rapidly. There were no cases of severe emphysema in nonsmokers. The incidence of severe emphysema in smokers is four times as high in St. Louis as in Winnipeg. Smoking and air pollution may act synergistically, producing and enhancing lung destruction.

ESTRADIOL PRODUCTION AFTER OVARIECTOMY FOR CARCINOMA OF THE BREAST

J. J. Barlow, K. Emerson, Jr., and B. N. Saxena (245 Pond Ave., Brookline, Mass.)

New Eng. J. Med. 280:633-637, (March 20), 1969.

Pre- and post-castration estradiol production rate measurements indicated that postmenopausal ovaries made no contribution to estrogen production. A review of previous reports of estrogen measurements and of beneficial responses following ovariectomy in postmenopausal women indicated that there is very little evidence to support the policy of therapeutic castration in such patients with breast cancer. Therapeutic oophorectomy without adrenalectomy is probably not justified in postmenopausal women with breast cancer.

VILLOUS ADENOMAS OF THE COLON, BENIGN OR MALIGNANT?

R. O. Olson, Jr., and W. C. Davis (4101 Woolworth Ave., Omaha)

Arch. Surg. 98:487-492, (April), 1969.

Thirty-five percent of 110 clinically benign villous adenomas were malignant. The microscopic criterion for malignancy was invasion of the muscularis mucosa. Comparison was made between these lesions found in a 17-year period at the University of Nebraska Hospitals and those reported in the English language during the last 20 years. A cancer operation for all villous adenomas above the peritoneal reflection is recommended. When the patient's condition permits, this is also the optimal therapy for malignant distal lesions. This neoplasm should be called "villous tumor of the colon" in order to avoid connotations of benignity implied by the term "adenoma." Patients with villous tumors should be catalogued separately.

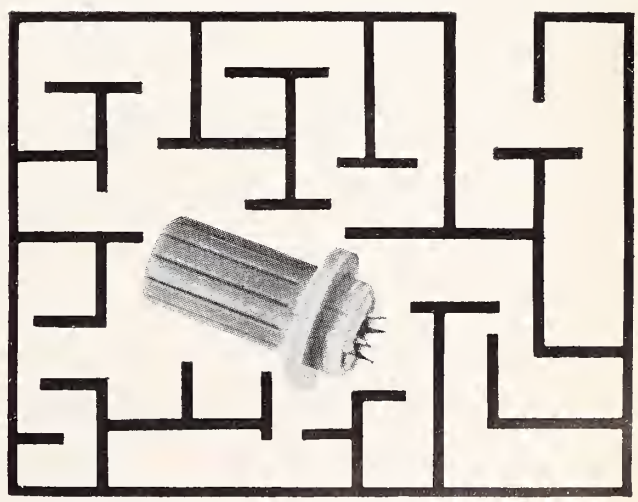
TREATMENT OF MASSIVE DIVERTICULAR HEMORRHAGE

F. W. Taylor and L. I. Epstein (Marion County General Hospital, Indianapolis)

Arch. Surg. 98:505-508, (April), 1969.

Some reports suggest that emergency colonic resection is the treatment of choice in patients with massive diverticular hemorrhage. A review of 76 consecutive cases forms a strong argument against early and "aggressive" operative management and favors more conservatism. There is no unanimity as to what constitutes

Continued



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"massive bleeding" in this disease. Amount of blood replacement was used as a basis of severity in groups of operated and unoperated bleeders.

APPENDECTOMY IN CHILDREN WITH ACUTE RHEUMATIC FEVER

J. S. Lin and R. R. Torres (451 Clarkson Ave., Brooklyn, N.Y.)
Pediatrics 43:573-577, (April), 1969.

Clinical and laboratory data on five appendectomy patients, later proved to have acute rheumatic fever, indicate that abdominal pain simulating acute appendicitis can be presented as the only initial symptom in acute rheumatic fever. Awareness and the presence of high fever, rapid sedimentation rate, prolonged P-R interval, and 4+ C-reactive protein usually help to make the differential diagnosis. If doubt remains surgery is recommended since these patients tolerate anesthesia and laparotomy very well.

CHOLANGIOGRAPHY VS. EXTRADUCTAL PALPATION

E. J. Rupnik, R. E. Carr, and E. L. Williams (Naval Hospital, Portsmouth, Va.)
Milit. Med. 134:169-176, (March), 1969.

Extraductal palpation of the extrahepatic biliary tree, employing the Kocher maneuver, has been reemphasized after reviewing 100 consecutive patients in whom it was used. It is an accurate method (1% error) for determining the presence or absence of extrahepatic ductal stones. The technique is simple and does not require elaborate equipment. When used routinely, its diagnostic accuracy exceeds that of operative cholangiography (6% error).

HYPERBARIC OXYGEN IN MENINGITIS AND SEVERE INFECTIONS OF THE NEWBORN

C. Martin et al. (Hopital des Enfants, Bordeaux, France)
Ann. Pediat. 45:113-116, (Feb. 2), 1969.

Hyperbaric orygen under moderate pressure was used as an accessory form of treatment in four patients with neonatal meningitis, all of whom recovered. During severe infections, hyperbaric oxygen reduces shock and renders antibiotics more effective. It also seems to have a bacteriostatic effect.

BELL'S PALSY

L. W. DeSanto and H. A. Schubert (Scott and White Clinic, Temple, Tex.)
Arch. Otolaryng. 89:700-702, (May), 1969.

Bell's palsy was observed in a man who had experienced similar paralysis of the opposite side of his face eight years previously. A review of his family history revealed that nine immediate relatives had undergone a total of ten unexplained attacks of facial paralysis. Seven of them were under 30 years of age when the palsy occurred. An anatomic variation of the fallopian canal or stylomastoid foramen that is familial is considered a factor in the pathogenesis of Bell's palsy. This thesis can be tested by polytomography and studies of temporal bone sections in persons who have had peripheral facial paralysis. ◄

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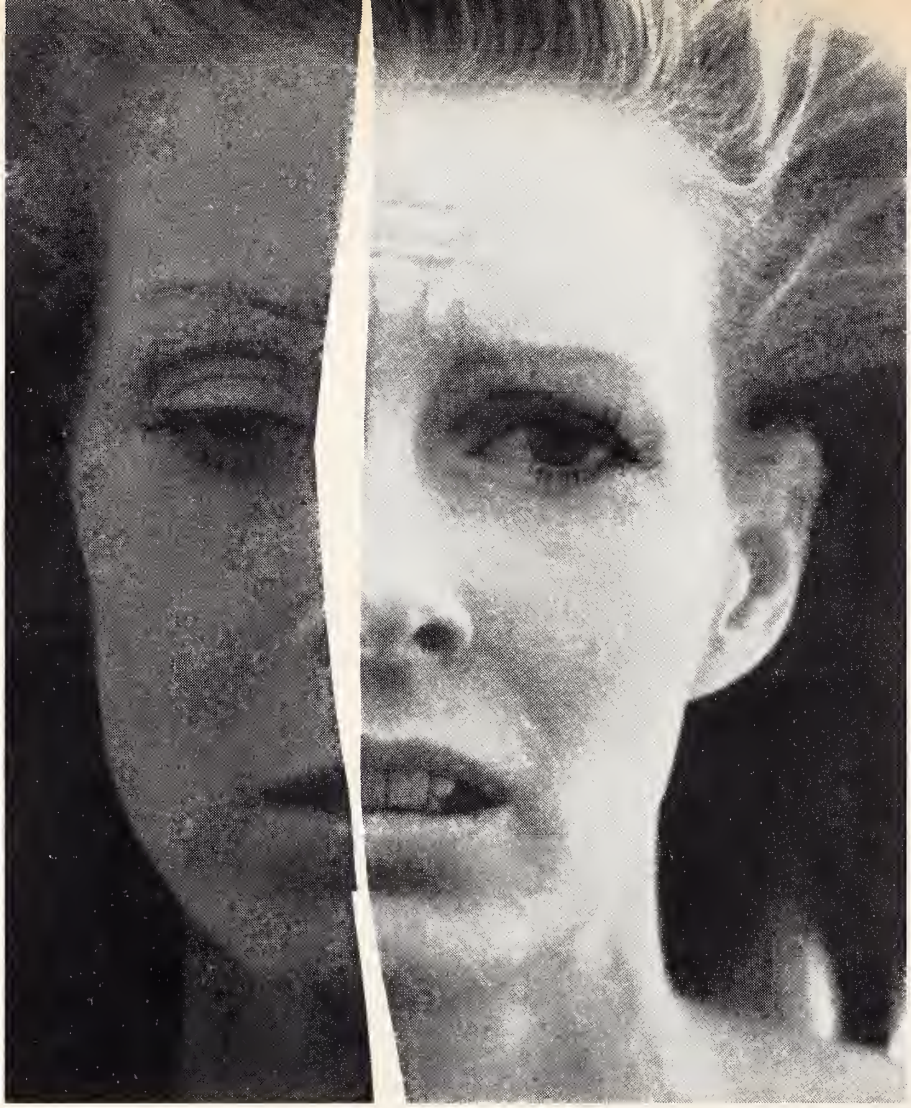
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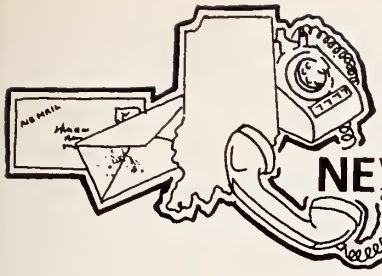
Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

SANDOZ PHARMACEUTICALS, HANOVER, N.J. SANDOZ 69-384



NEWS NOTES

Indiana Physicians Re-Elected To AAGP Active Membership

Many Indiana physicians have been re-elected to active membership in the American Academy of General Practice. Re-election signifies that the physician has successfully completed 150 hours of accredited postgraduate medical study in the last three years.

The Indiana physicians named are: Drs. Parker W. Snyder, Peru; Gene E. Ress, Tell City; Kenneth I. Sheek, Greenwood; Charles X. McCalla, Paoli; Edward F. Bloemker and Joseph H. Tuchman, Indianapolis; Marvin L. McClain, Scottsburg; Frederic L. Schoen and Marvin E. Priddy, Fort Wayne; E. M. Hoetzer, New Haven; Frank W. Bussard and Edward A. Davis, South Bend; Larkin D. Denton, Greentown; Julius T. Steffen, Wabash; Paul A. Eiler, North Manchester and Richard A. Jordan, Corydon.

Others named were: Drs. Richard P. Miethke, James E. Moneyhun, Warren C. Polhemus, Harry D. Webb, James R. Drake and Lawrence M. Gholz, all of Anderson; Frank A. Benchik, Munster; Charles D. Egnatz, Schererville; Ralph A. Lundeberg, Griffith; Edward D. Gourieux, Evansville; Edwin B. Bailey, Linton; Cecil R. Burket, Bremen; Kenneth E. Bobb, Seymour; C. R. Chambers, Union City; Bill E. Freeland, Batesville; Homer R. Swihart and Robert L. Bender, Elkhart; Francis A. Streck, Lawrenceburg; William N. Horst, Crown Point; Edward L. Hollenberg, Winamac; John D. Wilson, Evansville and Max E. Freeman, Carmel.

Dr. Wilbur Clarifies the AMA Position on the "Knowles Affair"

(Editor's Note: The following clarification of AMA's position regarding the potential appointment of John Knowles, M.D., to be assistant HEW secretary for health and scientific affairs was made last month by Dwight L. Wilbur, M.D.)

The text of Dr. Wilbur's statement:

"The following facts concerning the appointment of an assistant secretary for health and scientific affairs should be kept in mind in the whole matter of the appointment . . . .

"1. At the request of Mr. Finch, the AMA submitted a list of candidates for all top appointive officers in HEW including that of assistant secretary for health and scientific affairs. The three AMA candidates for this latter post were Drs. W. Clarke Wescoe, Richard S. Wilbur and John R. Hogness.

"2. Although I was in contact with Mr. Finch a number of times in person and by telephone, at no time from the first of January until June 27 did he indicate to me that Dr. John Knowles was his candidate for this position. He discussed the possibility of Dr. Knowles' appointment on a number of occasions, but there was never any indication to me that Doctor Knowles was his man. In fact, he recognized and expressed significant problems in such a potential appointment. . . .

"3. I made an agreement with Mr. Finch that we would not conduct a campaign in behalf of three AMA candidates. This was done at Mr. Finch's request and explains why the AMA remained essentially silent during this long period.

"4. Mr. Finch indicated to me and others that he felt the AMA nominees were excellent candidates. After Dr. Wescoe withdrew, Mr. Finch indicated to me and others on many occasions that the appointment of one or the other of the AMA candidates might well be just a matter of 'a few days.' Each of them was thoroughly investigated by the FBI. It was not until a few days before Dr. Egeberg's appointment that for the first time Mr. Finch indicated that the AMA candidates were not acceptable. This was at a time that the nomination of Dr. Knowles was withdrawn or not made.

"5. I found it exceedingly difficult to communicate with Mr. Finch and at one time was unable to contact him for a period of six weeks, although I was in touch with his office by telephone at least two or three times each week during this period.

"I have stated publicly that I think everyone lost in the Knowles affair. Certainly the Department of Health, Education and Welfare, the AMA and Doctor Knowles and particularly Mr. Finch did. The whole situation was most regrettable, but under the circumstances as the situation developed and as a vigorous campaign was mounted in behalf of Dr. Knowles, and not for the excellent candidates of the AMA, I believe the public, press, and the profession did not have the facts on which to make a fair and reasonable judgment concerning this situation."

Hospital Staff Officers

Dr. John O. Butler has been named president of the medical staff of St. Francis Hospital, Beech Grove.

Other officers are: **Dr. Charles Thomas,** president-elect and **Dr. Elsworth Stucky,** secretary-treasurer.

Physicians Named

Two Indianapolis physicians have been named to one-year terms with the American Academy of General Practice.

Dr. A. Alan Fischer has been appointed to the publications committee and **Dr. Lester D. Bibler** to the committee on international affairs.

Dr. Martin Elected

Dr. Freeman Martin, Indianapolis, has been elected to the board of directors of the Boy's Club Association of Indianapolis.

Royal Society of Medicine Foundation Fellowship Awards

The Royal Society of Medicine Foundation, with headquarters in New York City, has announced that its first two Traveling Fellowship Awards will go to Dr. Jean D. Wilson of the University of Texas Southwestern Medical School to do advanced studies at Strangeways Research Laboratory of Cambridge University and to Dr. James T. Kalivas of Harvard Medical School who will conduct nine months of research at King's College Hospital in London.

The Royal Society of Medicine, founded in 1805, includes nearly 1,300 Americans in its membership of 13,000. The foundation was formed recently by leaders in the United States and Great Britain to encourage U.S. citizens and institutions to support medical research and to foster closer relations between the medical professions of the two countries.

Dr. Klassen Speaks

Dr. Otto D. Klassen, Elkhart, conducted a seminar recently at Indiana University at South Bend. Topic of the seminar was the family as an agency for change.

Continued

NEWS NOTES

Continued

Rotary Speaker

Speaker at a recent meeting of the Terre Haute Rotary Club was **Dr. Harris B. Shumacker, Jr., Indianapolis,** who spoke on the problems of heart transplants and the possible development of mechanical substitutes.

Speaks at Coffee

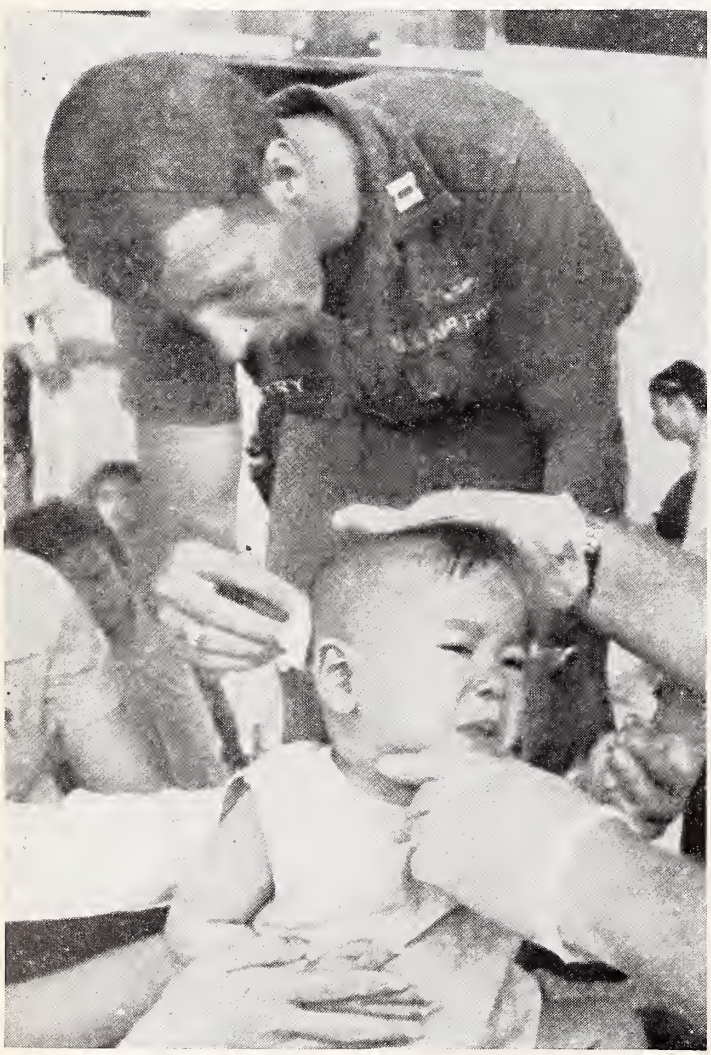
A "thank-you" coffee for volunteers in the annual Mother's March for the March of Dimes was held recently at the Kokomo YWCA. Guest speaker was **Dr. Richard Halfast,** medical advisor to the local chapter of the March of Dimes.

Jayshees Speaker

Dr. Virgil Graber, Elkhart, conducted a question and answer session after the showing of a film on cancer recently before a meeting of the Elkhart Jayshees.

Mental Health Workshop

Dr. Kenneth Lehman, Topeka, gave his views on mental retardation and mental health recently as a member of a panel which appeared before a public workshop and dinner co-sponsored by the LaGrange County Retarded Children's Association and the Mental Health Association of LaGrange County.



U. S. AIR FORCE Captain G. James Berry, of Indianapolis, examines a youngster at Ngoc Ninh Orphanage, near the base at Phan Rang Ab, Republic of Vietnam. Berry, a flight surgeon with the 35th USAF Dispensary, is part of an Air Force medical team that assists Vietnamese personnel at the recently opened orphanage.

Dr. Gardiner Elected

Dr. Sprague H. Gardiner, Indianapolis, has been re-elected secretary-treasurer of the American College of Obstetricians and Gynecologists.

Dr. Kohne is Speaker

The second talk in a "Love and Marriage" series was given recently by **Dr. Robert W. Kohne, Lafayette,** at Saint Thomas Aquinas Center there. His topic was "A Physician Looks at Love and Marriage."

Upjohn to Replenish Panalba Supplies Following Federal Decree

The Upjohn Company has announced that depleted supplies of Panalba are being rapidly restored following a decree by Federal Judge W. Wallace Kent which withheld the effect of the FDA ban on Panalba.

Judge Kent ruled that the FDA could not refuse to certify batches of Panalba for reasons other than failure to comply with existing technical specifications.

Coronary Care Speaker

Dr. C. L. Wise, Camden, spoke to the Florence Nightengale club of Logansport recently on his visits to coronary care units throughout the United States.

International Surgery Announces Journalism Award for Residents

International Surgery, the journal of the International College of Surgeons, announces a cash award of $500 for the best scientific paper submitted by a surgical resident. Full details may be obtained by writing International Surgery, 1516 N. Lake Shore Drive, Chicago, 60610.

Officers Named

New officers of the Clinical Society of the Indianapolis Diabetes Association have been announced. They are: **Drs. Richard C. Powell,** president; **A. S. Ridolfo,** first vice-president; **John A. Galloway,** second vice-president; **George Klutinoty II,** secretary and **M. R. Shafer,** treasurer.

Dr. Hunter is Fellow

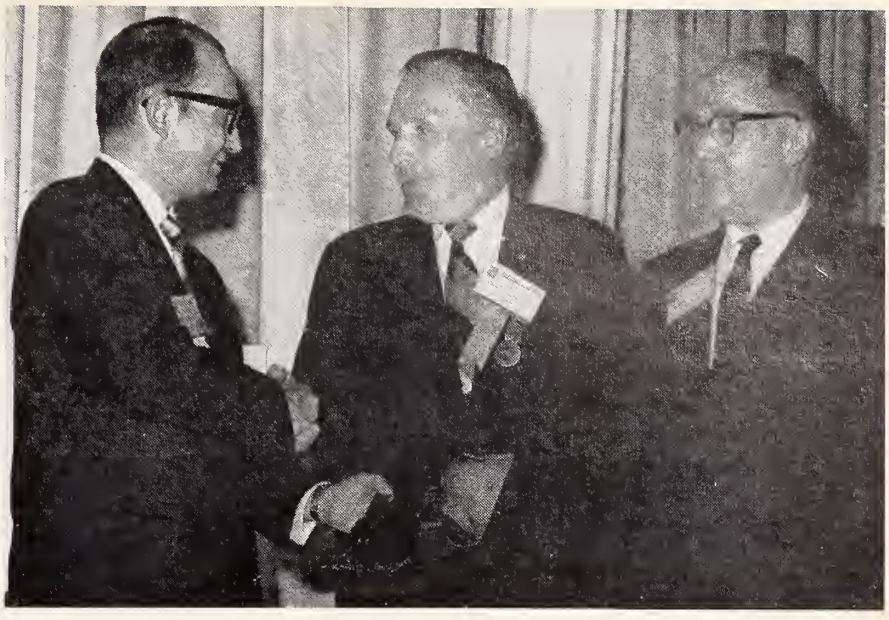
Dr. Dean M. Hunter, Lafayette, has been installed as a Fellow of the American College of Obstetricians and Gynecologists.

Dr. Harris Speaks

Dr. C. Glenn Harris, South Bend, spoke recently before the second conference on "Understanding the Teenager in Your Life" in Elkhart. His topic was "Their Dilemmas in Deciding Who Their Parents Are."

Dr. Westerman Named

Dr. Richard L. Westerman, Zionsville, has been appointed as an Associate Director of Clinical Research in the Department



DR. DONALD WOOD, state AMPAC chairman, accepts the AMPAC award recently as Dr. Patrick J. V. Corcoran, ISMA president, looks on. The award was made at the AMPAC Awards Dinner during the AMA/AMPAC Public Affairs Workshop recently in Chicago.

of Clinical Pharmacology of the Dow Human Health Research and Development. Dr. Westerman was formerly associated with Mead Johnson Company at Evansville.

Evening Missions Event

The Auburn First United Methodist Church featured **Dr. Lee Kinzer, Markle,** in an evening missions program recently. Dr. Kinzer spoke on his three-week visit in the Congo and 10 days in Kenya.

Dr. Swaim Elected

Dr. J. Franklin Swaim, Rockville, has been elected to a three-year-term on the Indiana State University Alumni Advisory Council as representative of his district.

Dr. Drummy Speaks

Dr. William W. Drummy, Terre Haute, addressed the Vigo County Council recently on elements of an ambulance service proposal to replace the services by local funeral homes, many of whom threatened to discontinue ambulance service at the end of last year. The service by the funeral homes has been continued, while the possibility of a single ambulance service taking over the task is examined.

Dr. Willis is Fellow

Dr. Robert L. Willis, Jr., Fort Wayne, has been made a Fellow of the American College of Radiology. Dr. Willis is a staff member of Lutheran Hospital.

Dr. Stander Named

Dr. Richard W. Stander, now professor of obstetrics and gynecology at the University of Cincinnati, has been elected chairman of the district of the American College of Obstetrics and Gynecology which contains Indiana, Ohio, Kentucky, Michigan and western Ontario.

Indiana Home Conducts Money Raising Campaign

Indiana Home, an institution for the treatment of alcoholics, has been active in Indianapolis for over 20 years, caring for alcoholics in increasing numbers. Six hundred and sixty-six patients were treated in 1968.

The need for larger quarters and the necessity of providing treatment for woman as well as men has prompted plans for building a new facility at the corner of 16th Street and Northwestern Avenue in Indianapolis. This non-profit tax exempt institution is now conducting a money-raising campaign to finance new construction.

The new "home" will have 60 beds, five times as many as the present building. It will be able to treat as many as 3,000 alcoholics each year. It is estimated that there are 60,000 potential alcoholics in Indianapolis and vicinity.

Dr. Muller Honored

Dr. Paul F. Muller, Indianapolis, newly-elected president of the medical staff of St. Vincent's Hospital, and 12 past presidents of the hospital were honored recently at the first annual President's Banquet.

Dr. Conley Speaks

Dr. Thomas Conley, Kokomo, presented a slide lecture on anatomy and physiology at the first of three public sessions about family life recently at Sycamore School there.

PTA Speaker

Dr. Richard Yoder, Elkhart, spoke on "Human Growth and Development" recently before the Beardsley Parent Teacher Association at Elkhart.

Dr. Campbell Addresses Group

Dr. H. Edwin Campbell, Indianapolis obstetrician and gynecologist, spoke to the Marion County Extension Homemakers Club recently. His topic was "Stages and Changes of Women."

Health Insurance Institute Offers New Resource Document

The "growing and diverse sources of information" on comprehensive health planning are summarized in a new resource document published by the Health Insurance Institute, 277 Park Ave., New York City, 10017.

Entitled "Comprehensive Health Planning Selective Reading," the 48-page annotated bibliography was prepared in cooperation with the Institute of Life Insurance and the Health Insurance Association of America.

Continued

It contains more than 150 listings of papers, articles and publications on major aspects of comprehensive community health planning. Subject matter in seven categories include comprehensive community planning, planning theory and techniques, comprehensive health planning, health services planning, health facilities planning, health manpower planning, and environmental health planning.

The HII said the document is part of an ongoing program on behalf of the nation's insurance companies to contribute to the information resources that are essential to meeting the nation's health needs and goals. The bibliography is designed to compliment the activities of the Health Insurance Council Program for Community Health Action Planning (HICHAP).

Distribution is being planned to health planning agencies, health educators, government agencies, medical writers, hospital and medical associations, and insurance people involved in local planning programs.

Guest Speaker

Dr. Richard M. Nay, Indianapolis, was guest speaker at Beech Grove United Methodist church recently. He discussed his medical missionary activities in Africa.

Dr. Bacala Cited

Dr. Jesus Bacala, Scottsburg, was recently honored by the mayor of Louisville as one of the city's "Ambassadors of Goodwill." Dr. Bacala was honored last year by the governor of Kentucky who made him an honorable member of the Venerable Order of Kentucky Colonels.

Prosthetic Care for the Medicare Patient



When medically prescribed, the Medicare program will provide prostheses for those covered under Part B. Medical Insurance. All HANGER offices, listed below, are providers of services under the Medicare program. HANGER provides each Medicare patient with high-quality prosthetic care. Included is: (1) a thorough examination of the stump, (2) expert evaluation, (3) detailed measurements, (4) careful recommendation as to whether the amputee will benefit from the prosthesis, and as to the best type of prosthesis for the patient. Meticulous construction of the prosthesis and correct fitting follow. During the lifetime of each patient, individual attention and supervision is available at any of the HANGER offices.

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3004 S. Wayne Ave., Fort Wayne, Ind. 46807

Physician is Speaker

Dr. Gabriel Rosenberg, Indianapolis pediatrician, spoke on "Drug Abuse and Our School Children and the Effects on Our Schools" recently at a meeting of the School 103 PTA.

Dr. Lands Elected

Dr. Robert M. Lands, Portage, has been elected to the board of directors of the Portage National Bank.

American College of Radiology To Open Washington Office

The American College of Radiology is opening a Washington office for permanent government liaison.

Otha W. Linton, formerly director of public relations at the college's Chicago office, will head the capital operation. The address is Suite 304 of the Bethesda-Bradley Bldg., 6900 Wisconsin Avenue, Chevy Chase, Maryland.

Dr. Melin Speaks

Dr. John R. Melin, Indianapolis obstetrician and gynecologist, spoke on "Childbirth" and "Becoming a Parent" recently before the University of Life group at North United Methodist Church, Indianapolis.

Mental Health Speaker

Dr. William E. Murray, superintendent of the New Castle State Hospital, spoke on "Recent Trends in Mental Health" recently at a meeting of the Dubois County Mental Health Association at Jasper.

Dr. Coats is Speaker

Dr. Eli Coats, Avon, addressed a recent meeting of the Never Too Late TOPS Club in Plainfield on his experiences in the field of weight reduction.

Dental Unit Speaker

"The Psychological Aspects of Dental Practice" was the topic chosen by **Dr. Robert Green, Fort Wayne** psychiatrist, when he spoke before a meeting of the Isaac Knapp Dental Society in Fort Wayne recently.

"The New Generation" Film Now Available to Physicians

The story of youth today—their ideas, ideals, problems, emotions and philosophy—is the basis of a new color film "The New Generation" produced by E. R. Squibb & Sons.

It is being made available by Squibb to physicians who wish to obtain it for group viewing in their local areas. In particular, it will be of help to physicians invited to speak before a group or organization or to contribute to a program. Write to Squibb Film Library, 600 Grand Avenue, Ridgefield, New Jersey 07657.

Physician Honored

Dr. Hanus J. Grosz, professor of psychiatry at I.U. Medical Center, has been presented the William M. Loehr Achievement Award by the John Shaw Billings History of Medicine Society and the I.U. Medical Center. Dr. Grosz was cited for advancing the education program for students at the medical center.

Dr. Brough Honored

Dr. A. Kathleen Brough, chief of staff at the Marion County Home and Julietta Convalescent Center, has been selected as one of America's Outstanding Young Women. Dr. Brough was selected for the honor in recognition of her achievements and contributions to her family, community, state and country.

Dr. Magnuson is Speaker

Dr. Charles W. Magnuson, South Bend, addressed a group of physicians recently in Michigan City. His topic was "Gastrointestinal Functional Diseases."

Dr. Plain Named

Dr. George W. Plain, South Bend, has been named to the newly-organized accreditation committee of the American Association of Medical Clinics.

Dr. Becker Elected

Dr. Harry Beeker, Indianapolis, was recently elected surgeon of the national Reserve Officers Association. A diplomate of the American Board of Surgery and a Fellow of the American College of Surgeons, Dr. Becker is also a past president of the Department of Indiana Reserve Officers Association.

Dr. Robinson Named

Dr. Daniel R. Robinson, at one time chief of staff of the Indianapolis VA Hospital and recently medical director for the 11-state southeast region of the Veterans Administration, has been named director of the San Francisco VA Hospital.

Emphysema is Topic

Dr. Herbert Frank, South Bend, spoke on "Lungs, Air and Emphysema" before District 7, Indiana State Nurses' Association, recently at the Holy Cross School of Nursing.

Dr. Owens Named

Dr. Walter L. Owens, Bloomington, has been named medical director of the Planned Parenthood Association Clinic there.

Medical Memorial

A plaque memorializing deceased members of St. Mary's Hospital medical staff was unveiled recently at Evansville, a gift of the hospital to the staff. **Dr. Herman M. Baker, Evansville's "Dean of Medicine"** accepted the memorial as senior staff member.

Good Work Recognized

Dr. Herbert I. Arbeiter, Hammond, was honored recently for his efforts in preventing poisoning accidents. The Safety Council of Hammond presented him with a plaque.

New Film, Brochure Offered by Ortho as Sex Education Aids

Ortho Pharmaceutical has a new informational film titled "A Concept of Family Life Education" and a brochure "Family Life (Sex) Education—A Professional Responsibility." Both are available to the medical profession.

The flim has a running time of 18 minutes. It is designed to stimulate positive attitudes about sex in the development of personality. The film and the brochure were made with the cooperation of the American College of Obstetricians and Gynecologists.

For full information write Ortho Pharmaceutical Corporation, Raritan, New Jersey 08869. ◄

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Joe M. Martin, M.D. Edgar C. Stuntz, M.D.	463-2695	Mrs. Margaret Keedy, A.C.S.W. Psychiatric Social Worker
		Elizabeth J. Snyder, R.N. Director of Nursing Service
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Bazylczuk, Jerzy W., 4520 No. Richmond, Chicago, Ill. 60625—*Radiology*

Carney, William M., 3715 Briarbridge Ln., Louisville, Ky. 40218—*Pathology*

Dicksheet, Sharad K., London Institute of Ophthalmology, Judd St., London, W. C. 1, United Kingdom—*Ophthalmology*

Dressler, Joachim A. W., 10 Northeast Dr., Rutland, Vt. 05701—*Pathology*

Heap, Lewis D., RD 195, Lakeside Rd., Mt. Kisco, N.Y. 10549—*Pathology*

Heiner, Elwood L., 1319 S. 18th E., Salt Lake City, Utah 84108—*Ear, Nose and Throat*

Kostecki, Richard J., 3339 Idlewild Dr., Augusta, Ga. 30904—*General Surgery*

O'Connor, Richard A., 1323 N. Elmwood, Peoria, Ill. 61606—*Public Health, Preventive Medicine*

Pelletier, Gerard J., 2 Rex Gate Dr., Toronto, Ontario, Canada 601—*Civil Service*

Poulos, James T., 7445 S. Euclid Pkwy., Chicago, Ill. 60649—*Internal Medicine*

Talsania, Suryakant J., 1727 Widener Place, Philadelphia, Pa. 19141—*General Surgery*

Welke, Robert E., R.F.D. Box 51B, Huntley St., Norwich, Vt. 05055—*Urology*

Wente, John A., 131 Dupre Ave., Norfolk, Va. 23503—*General Surgery*

Wu, Patrick, Darrington Clinic, Darrington, Wash. 98241—*General Surgery* ◄



SCIENTIFIC EXHIBIT APPLICATION FORM

Committee on Scientific Exhibits
Indiana State Medical Association
3935 N. Meridian Street
Indianapolis, Indiana 46208

Please send me an application form for a Scientific Exhibit at the ISMA Annual Convention, October 13-16, Indianapolis, Indiana.

I propose to exhibit_____

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Name_____

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Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION CLINICAL CONVENTION
Date Nov. 30-Dec. 3
Place Denver, Colo.

NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville

INDIANA ROENTGEN SOCIETY, INC.
Date March 1, 1970
Place Holiday Inn East, Indianapolis

INDIANA ACADEMY OF GENERAL PRACTICE
Date April 14-16, 1970
Place Indianapolis

INDIANA DENTAL ASSOCIATION
Date May 13-16, 1970
Place Indianapolis Hilton Hotel, Indianapolis

INDIANA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS
Date May 6-7, 1970
Place Stouffer's Inn, Indianapolis

BONE AND JOINT CLUB
Date October 22, 1969
Place The Athenaeum, Indianapolis

INDIANA SOCIETY OF ANESTHESIOLOGISTS
Date May 23, 1970
Place Marott Hotel, Indianapolis

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date May 6-8, 1970
Place Morris Inn, South Bend

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 13-16, 1969
Place Indianapolis

INDIANA HOSPITAL ASSOCIATION
Date October 15-17, 1969
Place Center for Continuing Education, University of Notre Dame, South Bend

INDIANA STATE NURSES ASSOCIATION
Date October 16-18, 1969
Place Civic Auditorium, Evansville

INDIANA ASSOCIATION OF PATHOLOGISTS
Date December 6, 1969
Place Indianapolis Motor Speedway Motel, Indianapolis

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Women aged 15 to 45 appear to be more prone than men to bloating, cramping pain of stress-related intestinal disturbances such as irritable or spastic colon.[1,2]

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In the experience of many physicians, women are more likely to reappear time after time with repeated complaints of lower G.I. distress.

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Often needed is therapy adequate to control both the somatic and the emotional components of psycho-abdominal complaints.

Definitive Dual Therapy

'Milpath' contains a proven synthetic anticholinergic useful for relieving hypermotility, spasm, and hypersecretion of the gastrointestinal tract.

In addition, 'Milpath' provides a time-tested tranquilizer for mild but effective anti-anxiety action.

With Flexible Dosage

- 'Milpath'-400 (meprobamate 400 mg. + tridihexethyl chloride 25 mg.) Usual adult dose: 1 tablet *t.i.d.* and 2 at bedtime.
- **When less tranquilization is required: 'Milpath'-200 (meprobamate 200 mg. + tridihexethyl chloride 25 mg.)**

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gently but firmly

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(meprobamate + tridihexethyl chloride)

relaxes smooth muscle and psyche

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(meprobamate + tridihexethyl chloride)

Relaxes smooth muscle and psyche



Usual Adult Dosage

One 'Milpath'-400 tablet, three times a day at mealtimes, and two at bedtime. For greater anticholinergic effect, two 'Milpath'-200 tablets, three times a day at mealtimes and two at bedtime. Doses of meprobamate above 2400 mg. daily not recommended.

Indications

Useful in organic and functional disorders with hypersecretion and hypermotility of G.I. tract, especially when accompanied by anxiety, neurosis, or tension states. Should be used as an adjunct to all other therapeutic measures.

Contraindications

Tridihexethyl chloride: Urinary bladder-neck obstructions, e.g., prostatic obstruction due to hypertrophy; pyloric obstructions because of reduced motility and tonus: organic cardiospasm (megaesophagus); glaucoma; possibly in stenosing gastric or duodenal ulcers with significant gastric retention.

Meprobamate: Previous allergic or idiosyncratic reactions to meprobamate.

Precautions

Tridihexethyl chloride: Use cautiously in elderly males (possible prostatic hypertrophy).

Meprobamate: Carefully supervise dose and amounts prescribed. Consider possible dependence or habituation (reported occasionally after excessive use), particularly in severe psychoneurotics, alcoholics, ex-addicts. Withdraw gradually (one or two weeks) after excessive dosage for weeks or months to avoid recurrence of pre-existing symptoms (e.g., anxiety, anorexia, insomnia) or withdrawal reactions (e.g., vomiting, ataxia, tremors, muscle twitching; rarely, epileptiform seizures, more likely in those with CNS damage or latent convulsive disorders). If drowsiness or visual disturbance occurs, reduce dose and advise against activity requiring alertness (driving, machinery operation). Effects of excess alcohol may be increased. Grand mal seizures possible in persons with both petit and grand mal. Prescribe cautiously in small amounts to patients with suicidal tendencies. Prescribe with caution to patients with known sensitivity to compounds of similar chemical structure, e.g., carisoprodol.

Side Effects

The following side effects of components may occur with 'Milpath'.

Tridihexethyl chloride: Severe effects rare on recommended dosage. Anticholinergic effects: dry mouth (fairly frequent at oral doses of 100 mg.), constipation or "bloated" feeling. Possible: tachycardia, dilation of pupils, increased ocular tension, weakness, nausea, vomiting, headache, drowsiness, urinary hesitancy or retention, dizziness.

Meprobamate: Drowsiness, sometimes with ataxia, usually controlled by decreasing dosage, occasionally with aid of central stimulants (e.g., amphetamine). Rarely, allergic or idiosyncratic reactions (usually after one to four doses); in mild form: itchy, urticarial or erythematous, maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever, transient leukopenia, and one fatal bullous dermatitis (after meprobamate and prednisolone) reported. More severe, very rare hypersensitivity: fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (one fatal), anuria, anaphylaxis, stomatitis and proctitis. Treat symptomatically (e.g., epinephrine, antihistamines, possibly hydrocortisone); stop and do not restart the drug. Isolated agranulocytosis, thrombocytopenic purpura, one fatal aplastic anemia reported, but only in presence of known toxic drugs, porphyric symptoms reported but relationship not established. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation reported by one observer. Fixed drug eruption with meprobamate and cross reaction to carisoprodol reported.

Suicidal attempts may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse, and death. Excessive dosage has led rapidly to sleep, then reduction of vital signs to basal levels. Empty stomach, and if respiration becomes very shallow and slow, cautiously give CNS stimulants (e.g., caffeine, pentylenetetrazol, amphetamine); also pressor amines if indicated.

Supplied

In two strengths:

'Milpath'-400: Yellow, scored tablets.

'Milpath'-200: Yellow, coated tablets.

Before prescribing, consult package circular.

References

1. Harrison, T. R., et al.: Principles of Internal Medicine, Fifth Edition, New York, The Blakiston Division, McGraw-Hill Book Company, 1966, p. 1019. 2. Bockus, H. L.: Gastroenterology, Second Edition, Philadelphia & London, W. B. Saunders Company, 1964, Vol. II, p. 729 et seq.

(1928A01J)

FUTURE MEETINGS, SEMINARS, COURSES

Western Conference on Criminal and Civil Problems

The first meeting of the Western Conference on Criminal and Civil Problems will be held May 14 through 16, 1970, in the Broadview Hotel, Wichita, Kansas.

The conference is a newly-formed forensic science group designed to foster advanced education in the field of medicine, the specialized medical-legal areas of pathology and psychiatry, law, and police administration and sciences. The meeting will attract most of the nation's forensic pathologists, in addition to leaders in law, medicine and police sciences.

Dr. Robert Borkenstein, Professor of Police Administration, Indiana University, will be one of the lecturers on Police Science.

Mayo Clinic Announces Annual Clinical Reviews

The Mayo Clinic announces its annual "Clinical Reviews" a program of lectures and discussions on problems of general interest in medicine and surgery.

Identical sessions are offered on November 3, 4 and 5 and again on November 10, 11 and 12. The program is acceptable for credit by the American Academy of General Practice.

The registration fee is $20; the attendance will be limited. Write immediately to M. G. Brataas, Mayo Clinic, Rochester, 55901.

International Symposium on Early Detection of Disease

An international symposium on early disease detection will be held in Elkhart on Monday, October 6 under the sponsorship of the Ames Company. Registration is open to all physicians, without fee.

Authorities from Sweden, England and the United States will discuss multi-channel automated equipment, cytology, mammography, automated EKG, diabetes detection programs and early disease detection programs. Advance registration forms may be obtained by writing Disease Detection Information Bureau, 3553 W. Peterson Ave., Chicago 60645.

Laser Light Exhibit to Appear At Cincinnati Art Museum

"Laser Light: A New Visual Art" will be the title of an exhibit which will appear at the Cincinnati Art Museum from November 13 to December 14.

It will be the first exhibition in the United States to explore the artistic possibilities of laser light. It is a collaborative undertaking of the University of Cincinnati Medical Center Laser Laboratory, the museum and six artists.

University of Chicago's Frontiers of Medicine Series

The University of Chicago announces the fifth of the series "Frontiers of Medicine" to be conducted on Wednesday afternoons at the Billings Hospital, 950 E. 59th Street, Chicago, as follows:

October 8, 1969—Liver Injury.
October 29, 1969—Community Related Health Care—New Patterns of Medical Practice.
November 12, 1969—Depression.
December 10, 1969—Trauma.
January 14, 1970—Recent Progress in Human Genetics.
February 11, 1970—Abnormal Uterine Bleeding and Pain.
March 11, 1970—Gout and Purine Metabolism.
April 8, 1970—Therapy of Leukemia and Lymphoma.
May 13, 1970—Neurological Aspects of Systemic Disease.

The fee for the entire series is $75; individual sessions $15. For additional information write—Frontiers of Medicine, University of Chicago, 950 E. 59th St., Chicago, Illinois 60637.

University of Kentucky Announces Series of Programs

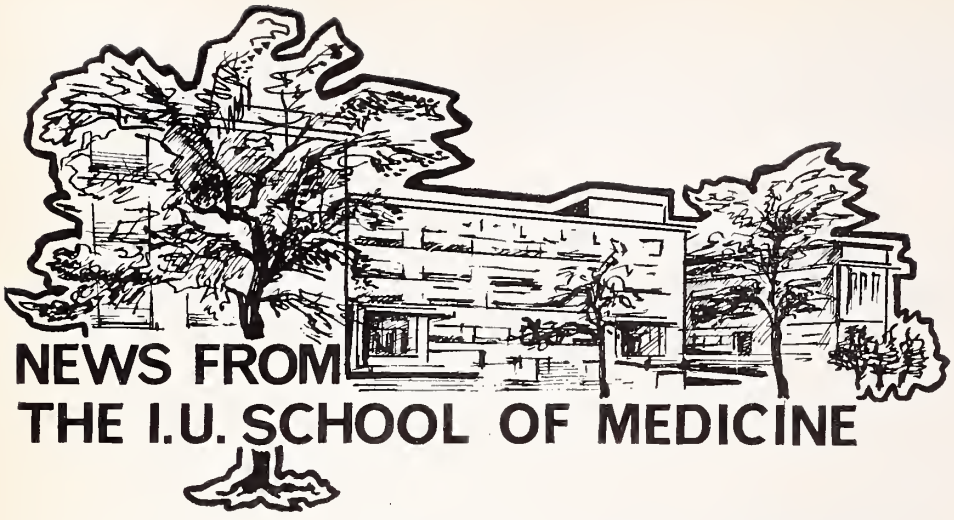
The University of Kentucky at Lexington announces a series of programs conducted by the continuing education department at the Albert B. Chandler Medical Center.

November 13 and 14, 1969—Surgical Care of Trauma.
December 19 and 20, 1969—Practical Ophthalmology for the Generalist.
January 21, 1970—Gastrointestinal and Biliary Tract Surgery.
January 29-31, 1970—Modern Methods for the Medical Work-Up.
March 18-20, 1970—Advanced Hematology Techniques.
March 18-20, 1970—Head and Neck Disorders in Children.
April 17-18, 1970—Mechanical Ventilators.
April 22, 1970—Diagnosis of Surgically Correctable Disorders.

Respiratory Problems in the Newborn Symposium will be in November

The Department of Pediatrics, University of Louisville School of Medicine presents its third annual Newborn Symposium, November 6-7.

Participants (alphabetically): Drs. Donald Buckner, Lawrence Davis, Peter Gruenwald, Marshall Klaus, Nicholas M. Nelson, and William A. Silverman. For information write: Dr. Billy F. Andrews, 323 E. Chestnut, Louisville, Kentucky 40202.



NEWS FROM THE I.U. SCHOOL OF MEDICINE

Major increases in the stipends paid to interns and resident physicians at the University Hospitals of Indiana University at Indianapolis have been announced by Dr. Glenn W. Irwin Jr., dean of the IUI School of Medicine, and Elton T. Ridley, director of the university hospitals.

Stipends for interns will be raised from $4,900 to $6,000 for the 1969-70 academic year.

Similar increases have been approved for physicians enrolled in residency programs at the university hospitals: stipends for physicians in the first year of residency programs will be raised from $5,600 to $6,500; stipends for the fourth year of residency will be raised from $7,100 to $8,000.

"These raises are absolutely necessary if we are to attract physicians to internships and residencies in the university hospitals," said Mr. Ridley. "The stipends paid by similar hospitals in other urban centers are approaching $10,000."

Dean Irwin said that recruitment for internships and residencies is directly related to recruitment for practice in Indiana.

"A variety of studies have demonstrated that physicians tend to open their practices where they complete their formal medical educations," he said. "If we fail to recruit for internships and residencies, then we will fail to recruit for practices." he said.

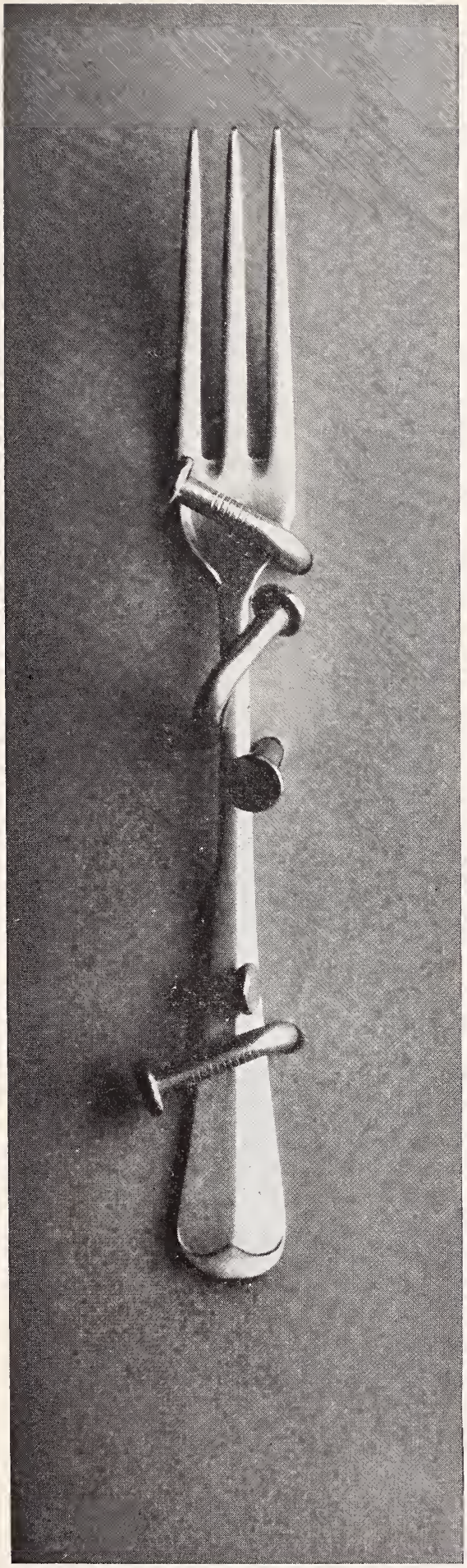
The university hospitals now support a majority—290 of 428—of the internships and residencies in Indiana.

More than $1,200,000 has been allocated for these programs during the 1969-70 academic year, compared with $886,530 for the current academic year. Nearly $890,000 of this will come from the operating budget of the university hospitals, which receive no state support for their education and service programs.

"Although the internship and residency programs are obviously programs which benefit all of the citizens of Indiana, they are supported primarily by the revenues of the hospitals," said Mr. Ridley. "This means that the costs of these programs must be included in our rate structure. The lack of state support for internships and residencies at the university hospitals forces some of the citizens—those who are patients at the university hospitals—to subsidize essential medical education programs for the entire state," he said.

The increased stipends for internships and residencies will add more than $250,000 to the operating costs of the university hospitals during the 1969-70 fiscal year.

"This is a major factor in the increases in room rates and surgery charges which we will be forced to adopt for the next fiscal year," said Mr. Ridley. "We regret this, but the method of financing this part of medical education in Indiana leaves us no choice." ◄



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Formulas: Each 'Dexamyl' *Spansule* capsule No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid (Warning, may be habit forming). Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital (Warning, may be habit forming).
Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Hyperexcitability, undue restlessness, hyperthyroidism, porphyria; in patients on MAO inhibitors.
Precautions: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence. Rarely, symptoms of toxic psychosis (hallucinations, confusion, panic states, etc.) may occur with amphetamines, usually after prolonged high dosage. In these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester.
Adverse Reactions: Overstimulation, restlessness, insomnia, g.i. disturbances, diarrhea, palpitation, tachycardia, elevated blood pressure, tremor, sweating, impotence and headache.
Supplied: In bottles of 50.

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curbs appetite
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INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—July, 1969

Disease	July 1969	June 1969	May 1969	July 1968	July 1967
Animal Bites	1408	1153	1431	1220	1245
Chickenpox	105	247	637	49	49
Conjunctivitis	150	121	199	103	98
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	25	9	36	7	26
Gonorrhea	707	566	582	521	425
Impetigo	212	58	98	108	116
Infectious Hepatitis	32	41	67	47	23
Infectious Mononucleosis	33	49	118	25	33
Influenza	237	368	1284	78	27
Measles					
Rubeola	14	15	133	22	21
Rubella	75	193	602	27	34
Meningitis, Meningococcal	1	6	3	0	1
Meningitis, Other	3	2	2	2	7
Mumps	99	236	485	100	261
Pertussis (whooping cough)	9	5	9	15	54
Pneumonia	173	146	271	126	109
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	416	386	865	311	220
Syphilis					
Primary & Secondary	33	34	39	20	13
All Other Syphilis	117	131	118	58	74
Tinea Capitis	8	2	10	8	6
Tuberculosis (Active)	81	97	42	83	70

★

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County, District News

Eighth District

New officers of the Eighth District Medical Society are: Drs. David Landon, Union City, president; C. R. Chambers, Union City, secretary-treasurer and Richard Ingram, Montpelier, trustee.

Dearborn-Ohio

The Dearborn-Ohio County Medical Society has elected Dr. Gary Scudder, Lawrenceburg, president; Dr. Lowell Hunter, Lawrenceburg, vice-president and Dr. Leslie M. Baker, Aurora, secretary-treasurer.

Harrison-Crawford

Dr. David Dukes is the new president; Dr. Richard Jordan the new vice-president and Dr. Samuel Martin the secretary-treasurer of the Harrison-Crawford County Medical Society. All of the new officers are from Corydon.

Jackson-Jennings

Newly-elected officers of the Jackson-Jennings County Medical Society are: Drs. W. F. Blaisdell, president; Slater Knotts, vice-president and John Linson, secretary-treasurer. All of the officers are from Seymour.

Kosciusko

The Kosciusko County Medical Society officers for the coming year are: Drs. William C. Parke, Warsaw, president and Clifford Fiscus, Warsaw, secretary-treasurer.

Parke-Vermillion

New president of the Parke-Vermillion County Medical Society is Dr. Weldon D. Britton, Montezuma.

Tippecanoe

The Tippecanoe County Medical Society held its annual picnic July 17 at the Monticello Country Club.

Vanderburgh

Dr. R. Case Hammond, Evansville, is the new president of the Vanderburgh County Medical Society.

Whitley

The Whitley County Medical Society has elected Dr. John L. Vogel, Columbia City as its new president. ◄

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2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

*"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

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Thiamine HCL . . . . . 10 mg.
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Methyl Testosterone . . 5.0 mg.
Thyroid Ext. (½ gr.) . . . 30 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY
Each orange tablet contains:
Methyl Testosterone . 12.5 mg.
Thyroid Ext. (1 gr.) . . . . 64 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

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Each white tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (¼ gr.) . . . 15 mg.
Ascorbic Acid (Vit. C) . 250 mg.
Thiamine HCL . . . . . 25 mg.
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Pyridoxine HCL . . . . . 5 mg.
Niacinamide . . . . . 75 mg.
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Deaths

Harry L. Cooper, M.D.

Dr. Harry L. Cooper, 81, died July 31 in South Bend. A gastroenterologist, Dr. Cooper had resided and practiced medicine in South Bend since his graduation in 1911 from the University of Michigan School of Medicine.

A veteran of World War I, Dr. Cooper was a member of the St. Joseph County Medical Society, a Senior Member of ISMA and a member of the 50-Year Club.

Robert W. McTurnan, M.D.

Dr. Robert W. McTurnan, 54-year-old Indianapolis physician and commander of the United States Army Reserve Medical Corps unit from Indiana and Michigan, died July 25 in Junction City, Kans.

Dr. McTurnan, a colonel in the Army Reserve, had been attending summer training at Fort Riley, Kans. Graduated from the I.U. School of Medicine in 1939, Dr. McTurnan had been an Indianapolis resident most of his life. He was a member of the Marion County Medical Society.

Ray B. Robertson, M.D.

Dr. Ray B. Robertson, physician on Indianapolis' eastside for 38 years, died July 10 at the age of 72.

Graduated from the I.U. School of Medicine in 1928, Dr. Robertson also held bachelor's and master's degrees in pharmacy from Purdue University. He was on the staffs of Methodist, St. Francis and Community hospitals and had formerly taught at the I.U. School of Medicine. He was a member of the Marion County Medical Society.

Murray M. Sears, M.D.

Dr. Murray M. Sears, 95, died June 11 in Norwalk, Conn., after a long illness.

A former member of the Elkhart County Medical Society, Dr. Sears was an eye, ear, nose and throat specialist for over 50 years, 36 of which were spent in Elkhart. He also was a member of the Elkhart General Hospital Medical Board for 25 years, the ISMA 50-Year Club and a Senior Member of ISMA.

H. C. Wallace, M.D.

Dr. H. C. Wallace, staff surgeon at Culver Hospital from 1935 until his retirement in 1963, died July 23 at his home in Crawfordsville.

After retiring as a surgeon, Dr. Wallace was plant physician for the R. R. Donnelley & Sons Company in Crawfordsville for two years. Graduated from Rush Medical College in 1922, Dr. Wallace was a Senior Member of ISMA and member of the Montgomery County Medical Society.◀

The Real Emergency

Can your patients recognize a real emergency? Or is, as they see it, every bump or bruise, ache or pain an emergency?

The AMA's new pamphlet, "When To Call or See Your Physician," establishes guidelines helpful to patients determining when to seek medical aid.

The pamphlet lists four indications which call for immediate medical attention — severity, persistence, repetition and doubt. Any one of the four is sufficient; two or more increase the urgency.

In addition, the pamphlet cites circumstances which indicate that a doctor's help is needed. Some of the common conditions described are blackouts, breathlessness, dizziness, fatigue, headaches, indigestion, itching, sores and swelling.

Single review copies may be obtained from the AMA's Health Education Department. Quantity orders are available from the Order Department at 15 cents each; 12 cents each for 100-499; 10 cents each for 500-999; 8 cents each for 1000 or more.

Association News

BOARD OF TRUSTEES

June 28, 1969

The Board of Trustees of the Indiana State Medical Association convened at 6:00 p.m., Saturday, June 28, 1969, in the headquarters building, 3935 N. Meridian Street, Indianapolis, with Dr. Donald R. Taylor, chairman, presiding.

Roll call showed the following present:

District	Trustee	
1	Gilbert M. Wilhelmus, Evansville	Present
2	Joe Dukes, Dugger	Present
3	Donald M. Kerr, Bedford	Present
4	Robert M. Reid, Columbus	Absent
5	Wilbert McIntosh, Riley	Absent
6	Stephen Smith, Knightstown	Present
7	James H. Gosman, Indianapolis	Present
8	Donald R. Taylor, Muncie	Present
9	Peter R. Petrich, Attica	Present
10	Vincent J. Santare, Munster	Present
11	Lowell J. Hillis, Logansport	Absent
12	William R. Clark, Ft. Wayne	Present
13	Otis R. Bowen, Bremen	Present

District	Alternate	
1	Eugene W. Austin, Evansville	Absent
2	Betty Dukes, Dugger	Absent
3	E. L. Wallace, New Albany	Absent
4	Jack Shields, Brownstown	Absent
5	C. M. Schauwecker, Greencastle	Present
6	Frank H. Green, Rushville	Absent
7	John O. Butler, Indianapolis	Present
8	Paul W. Sparks, Winchester	Absent
9	Lindley H. Wagner, Lafayette	Absent
10	C. T. Disney, Gary	Absent
11	James A. Harshman, Kokomo	Present
12	Frederic L. Schoen, Fort Wayne	Present
13	G. Beach Gattman, Elkhart	Absent

Officers:

Patrick J. V. Corcoran, Evansville	Present
Lowell H. Steen, Hammond	Present
Lester H. Hoyt, Indianapolis	Absent
Malcolm O. Scamahorn, Pittsboro	Absent

Journal:

Frank B. Ramsey, Indianapolis	Present

Executive Committee:

Ralph V. Everly, Indianapolis, chairman	Absent
Burton E. Kintner, Elkhart, member	Present

Delegates and Alternate Delegates to AMA:

Guy A. Owsley, Hartford City	Present
Jack E. Shields, Brownstown	Absent
Don E. Wood, Indianapolis	Present
Eugene F. Senseny, Ft. Wayne	Present
Frank H. Green, Rushville	Absent
Maurice E. Glock, Ft. Wayne	Present
Dwight W. Schuster, Indianapolis	Absent
James A. Harshman, Kokomo	Present
E. S. Rifner, Van Buren	Present
Kenneth O. Neumann, Lafayette	Present

Guests:

Mr. Ralph Hamill, Indianapolis, attorney
Lall G. Montgomery, Muncie, delegate, AMA Section on Pathology

Staff:

Robert J. Amick, field secretary
Kenneth W. Bush, administrative assistant
Jas. A. Waggener, executive secretary

Minutes of the meetings held March 26, 1969 and April 13, 1969 were presented for approval and two corrections were requested in the minutes. On page 14 of the minutes, under report of the Board of Trustees Committees, in the first line of the second paragraph, the ninth district should be changed to the eleventh district. On motion of Drs. Harshman and Steen, the alternate delegates who were reported as absent are to be stricken from the minutes inasmuch as they were not required to attend the meeting but the names of the alternates who did attend should be listed as present.

The chairman called on Mr. Ralph Hamill, attorney, to discuss the suit against Blue Cross and following Mr. Hamill's report, discussion was held. It was moved and seconded that the attorney should pursue this suit to a final conclusion.

The balance of the evening was spent in a discussion of the resolutions and reports to come before the annual meeting of the AMA in New York. The AMA delegation from Indiana discussed these for the information and for advice from the Board. It was the consensus of the Board that decisions on reports of committees and councils of the AMA should be left to the decision of the delegation in consultation with the Executive Committee.

The Board then recessed to meet again at 9:00 a.m. on Sunday morning, June 29th at the headquarters building.

BOARD OF TRUSTEES

June 29, 1969

Dr. Donald R. Taylor, chairman, called the Board to order at 9:00 a.m., Sunday, June 29th, at 9:00 a.m. in the Columbia Club and roll call showed the following present:

District	Trustee	
1	Gilbert M. Wilhelmus, Evansville	Present
2	Joe Dukes, Dugger	Present
3	Donald M. Kerr, Bedford	Present
4	Robert M. Reid, Columbus	Absent
5	Wilbert McIntosh, Riley	Absent
6	Stephen Smith, Knightstown	Present
7	James H. Gosman, Indianapolis	Present
8	Donald R. Taylor, Muncie	Present
9	Peter R. Petrich, Attica	Present
10	Vincent J. Santare, Munster	Present
11	Lowell J. Hillis, Logansport	Absent
12	William R. Clark, Ft. Wayne	Present
13	Otis R. Bowen, Bremen	Present

District	Alternate	
1	Eugene W. Austin, Evansville	Present
2	Betty Dukes, Dugger	Absent
3	E. L. Wallace, New Albany	Absent
4	Jack E. Shields, Brownstown	Absent
5	C. M. Schauwecker, Greencastle	Present
6	Frank H. Green, Rushville	Absent
7	John O. Butler, Indianapolis	Present
8	Paul W. Sparks, Winchester	Absent
9	Lindley H. Wagner, Lafayette	Present
10	C. T. Disney, Gary	Absent
11	James A. Harshman, Kokomo	Present
12	Frederic L. Schoen, Ft. Wayne	Present
13	G. Beach Gattman, Elkhart	Absent

Officers:

Patrick J. V. Corcoran, Evansville, president	Present
Lowell H. Steen, Hammond, president-elect	Present
Lester H. Hoyt, Indianapolis, treasurer	Absent
Malcolm O. Scamahorn, Pittsboro, assistant treasurer	Absent

Journal:

Frank B. Ramsey, Indianapolis, editor	Present

Executive Committee:

Ralph V. Everly, Indianapolis, chairman	Absent
Burton E. Kintner, Elkhart, member	Absent

Guests:

A. C. Offutt, Indianapolis, State Health Commissioner
Robert B. Stonehill, Indianapolis, coordinator, Indiana Regional Medical Program
Glen V. Ryan, Indianapolis, chairman, Blue Shield Board of Directors
Don Dian, Indianapolis, Indiana Student AMA
Pete Foster, Indianapolis, vice president, Indiana Student AMA

Staff:

Robert J. Amick, field secretary
Howard Grindstaff, field secretary
Kenneth W. Bush, administrative assistant
Jas. A. Waggener, executive secretary

The Board met in the Columbia Club due to the failure of the air conditioning in the headquarters building.

The chairman introduced to the Board Mr. Dian, president of the SAMA Chapter of the I.U. School of Medicine and Mr. Pete Foster, vice president of the group, who were attending as observers for the meeting of the Board.

Reports of Trustees

First District: Dr. Wilhelmus reported the following officers were elected at their district meeting: president, James L. Hobgood; vice president, Fred Smith and secretary-treasurer, Ray H. Burnikel.

Second District: Dr. Dukes—no report.

Third District: Dr. Kerr—no report.

Fourth District: Not represented—no report.

Fifth District: Dr. Schauwecker, alternate, reported that the 1970 district meeting would be the last Wednesday in May and reported the following officers were elected at the 1969 district meeting: president, Wm. Tipton; secretary-treasurer, C. M. Schauwecker and Dr. McIntosh, re-elected trustee.

Sixth District: Dr. Smith announced their 1970 district meeting would be held in New Castle and reported the following officers elected at the 1969 meeting: president, Perry F. Seal; vice-president, David E. Wynegar; secretary-treasurer, Mark Smith. Dr. Wynegar was elected alternate trustee.

Seventh District: Dr. Gosman—no report.

Eighth District: Dr. Taylor reported on the election of officers from his district: president, David Landon; secretary-treasurer, C. R. Chambers. Dr. Richard Ingram was elected trustee. He also reported the 1970 meeting would be held in Randolph County and Randolph County members would make the arrangements for the meeting.

Ninth District: Dr. Petrich announced their 1970 meeting would be held in Crawfordsville on June 11th.

Tenth District: Dr. Santare stated he would like to have clarification by the Board of the policy concerning the remission of dues. On motion of Dr. Santare and seconded by Dr. Steen, the question was referred to the Board Committee on Membership Matters for further clarification.

Eleventh District: Dr. Harshman—no report.

Twelfth District: Dr. Clark reported they had a very successful meeting and the following officers were elected: president, John Hartman; vice president, J. Robert Edwards; secretary-treasurer, DeWayne L. Hull. Dr. Kenneth Isenogle was elected to membership on the Blue Shield Board.

Thirteenth District: Dr. Bowen reported that the entire district was involved in working on Comprehensive Health Planning and announced their district meeting would be held September 17, 1969.

Reports of Guests

The chairman then called on Dr. Offutt for his report.

DR. OFFUTT: Thank you Mr. Chairman, members of the Board. On the 18th of April of this year, I received a letter which I solicited as a result of a phone call concerning the granting of permission to use Neo-Polycin ophthalmic ointment in lieu of 1% silver nitrate in the Daviess County Hospital in Washington for the prophylaxis of ophthalmia neonatorum. I told the caller to write such a letter, as a matter of fact, to write me two letters.

One of them was a request for a pilot study and the second was a letter requesting a change in the regulation concerning the prophylaxis of ophthalmia neonatorum in favor of Neo-Polycin or some other antibiotic in lieu of silver nitrate. I remind you that the law does not stipulate silver nitrate: the law stipulates that a prophylaxis for ophthalmia neonatorum be used in the eyes of the newborn. The regulations do, however, stipulate 1% silver nitrate. The suggestions for a change from silver nitrate to some other product have been repeated often in 1948, again in 1953, '56, '60 and '64. Each time it came to the Council through a commission or by some resolution passed by the Council and each time the Council has said that 1% silver nitrate should be continued. The last recommendation was to be found in the minutes of this body, then the Council, of January 12, 1964. The Council went on record, at that time, as sustaining the action of the State Board of Health and disapproving the use of a substitute preparation instead of silver nitrate in the eyes of the newborn. So we have gone the general route from the chemotherapy through the antibiotics.

I am told by Dr. Schroeder of the Daviess County Hospital, who is the individual who wrote me the letter, that Daviess County did sponsor the action of the House of Delegates at the last meeting in 1968 in Fort Wayne. The resolution was passed and quoting from *The Journal*, and I'll skip the "whereas's," saying that "Resolved by the Daviess-Martin County Medical Society in regular session this 9th day of September, 1968, that we request the Indiana State Medical Association to act for the removal of the obsolete law and its replacement with a more effective and less injurious law for neonatal prophylaxis." Obviously, it's necessary that I again bring this to your attention in order that we can re-evaluate the use of silver nitrate.

I have in front of me a resume' of all the states and the District of Columbia, Puerto Rico and the Virgin Islands. The interesting thing about that is that you'll notice that many of those states which permit the use of antibiotics also stipulate that their first choice is silver nitrate. With reference to the occurrence of ophthalmia neonatorum, we know that there's about a 0.2% incidence without prophylaxis. Silver nitrate reduces that incidence to 0.02% and the effectiveness, of course, is easily demonstrable. There have been some sporadic reports of chemical conjunctivitis but none of any significance that we can determine in Indiana or any of the other states and territories. Generally, what we've found over the years, and this has been brought up at previous meetings, is that the problem stems from improper use of silver nitrate. The dropper bottle which may have a possible rise in concentration due to evaporation and the precipitate that occurs when the silver nitrate solution is washed out of the eye with normal saline instead of distilled water.

Now we know that in some hospitals, and in practice, some of the OB people are using the single dose preparation using sterile distilled water and the incidence of chemical conjunctivitis is reduced to practically nothing. In my opinion it's apparent that some prophylaxis is needed. I would say to you that I believe that the 1% silver nitrate is effective. I think also that our information would indicate that any side effects are very rare and the potential dangers of producing drug-resistant organisms or hypersensitivity are practically nil.

I have been informed by Dr. Carl Huber, whom you all know, that the American Association for the Prevention of Blindness has recently asked the American Academy of Pediatrics to not recommend any antibiotic for the prophylaxis of ophthalmia neonatorum. It's been reported that the academy has agreed and has not approved any antibiotic. Dr. James Hawk, now of the State Board of Health, said that in looking over the information, he found no evidence in which there has been any investigation of the effectiveness of Neo-Polycin nor evidence of a manufacturer's recommendation for its use

for ophthalmia neonatorum specifically, therefore, its use would be as an experimental drug.

Neo-Polycin is also packaged in multi-dose tubes which of course would offer a chance for a possible cross-contamination. And there is a Neo-Polycin product that's a topical ointment with the added possibility of using topical rather than the ophthalmic ointment. There's a possibility that the infant may be infected after the day of the birth of the child and if Neo-Polycin has been used without approval, certainly the action would almost be indefensible. I asked Dr. D.G. Bernoske, also on our staff, long in practice in the northern part of the state, about this matter and he said that he would advise that we follow our regulations which simply means 1% silver nitrate.

I also checked with Dr. V. K. Harvey with reference to what's being done in the field of maternal and child health. The Academy of Pediatrics in 1964 recommended 1% silver nitrate or a suitable antibiotic if permitted by state law and approved by the hospital staff. The academy issued a statement that they studied this problem also in '55 and again in '58 and in '58 they did recommend the use of 1% silver nitrate as a prophylaxis. The '64 action apparently seemed to be negated by their recent action, at least as reported by Dr. Huber to me, in which they did not sanction the use of antibiotics. I shall not bore you further on this, Mr. Chairman. I'd like to have some guidance with respect to the re-evaluation of our regulations.

CHAIRMAN: Thank you, Dr. Offutt. Any discussion from the trustees on this matter? Is it acceptable?

CHAIRMAN: Yes.

Dr. Gosman moved that we go ahead with the present regulations and that a study be undertaken at Indiana University to determine once and for all the effectiveness or detriments of any of the other antibiotics in regard to this particular subject.

Dr. Kerr seconded the motion.

CHAIRMAN: We've had a motion offered which has been duly seconded—any discussion on this motion? Dr. Offutt, would you like to discuss the motion—would this satisfy your needs?

DR. OFFUTT: I believe actually, that it would. If we could get a real study but on the pessimistic side, I doubt whether we could actually get this done. I think it would be a tremendous problem in a private practice or in a hospital. Exactly what has been proposed by the motion supports our purpose to not stifle any effort to see if anything else would work as well.

CHAIRMAN: Any further discussion? Question has been called for—all in favor of the motion say "aye." Opposed? Motion is carried. Do you have any other items?

DR. OFFUTT: Yes sir. The matter of measles vaccine program has been considered by the Council before. Of course now it comes up with respect to German measles and you'll recall that we did set up, with your help, a rather productive program for regular measles vaccination. I would like again to solicit your approval and join with us in the same kind of a program for German measles using the new vaccine.

The points which I have here before me, of which there are ten, are identical with the ten you approved before except we changed the words to German measles. The method we used is the same, requisition by local health officers, vaccine furnished, single dose package complete with disposable syringe and needle. The decision as to how the program will be implemented will depend upon the plan adopted by the county medical society in conjunction with the local boards of health. The emphasis will be on getting the vaccine to children in kindergarten, first through six grades. This group should have initial priority to produce the greatest impact in control of German measles. No charge to be made for the vaccine. I repeat that no charge is to be made for the vaccine.

CHAIRMAN: What is your pleasure on this, gentlemen? This is the same program we approved.

Dr. Kerr moved that we approve this program in the same fashion. Seconded by Dr. Schauwecker and Dr. Bowen.

CHAIRMAN: Discussion? Call for the question—all in favor of the motion signify by saying "aye." Opposed? The motion is carried, we shall have this published in the *News Flash*, or in an early issue of *The Journal*.

DR. DUKES: May I ask a question?

CHAIRMAN: Yes, Dr. Dukes.

DR. DUKES: Is this proposed to be done in the doctor's office or in a community center like it's been done before?

DR. OFFUTT: It's a local option. Each county and society can operate however it desires. Some counties, I believe, I'm not sure of it, some of the counties did do it in their offices. I am sure that there were one or two that set up clinics. Did Marion County run a clinic, Dr. Gosman, do you remember?

DR. GOSMAN: Yes sir.

DR. OFFUTT: The other item is more or less a matter of information and here again I'd appreciate anything you could do to help us. A resolution of the House of Representatives was to have us find out about termination of pregnancy. That's the best way I can put it. We had a meeting about this and it was decided that hospitals and medical record librarians and the state medical association should be consulted before we move.

We met on June 4th and we have designed a report card which is headed "Confidential Report of Terminated Pregnancy Under Twenty Week Gestation." Name of hospital, city, age of patient, county of residence, and then whether it was spontaneous, complete, non-spontaneous, incomplete, therapeutic, and whether or not the patient was from out of state and the reason for therapeutic abortion. I might tell you that the words confidential, spontaneous, therapeutic in every instance are capitalized. Then there's a question—was the temperature 100.4 degrees or above during hospitalization? Yes or No. We'll have these cards ready for distribution after the first of August. And at that time, our communicable disease investigators will begin distribution to hospitals.

The reporting period will be from October 1, 1969 through September 30, 1970. Confidential report cards will be turned in to us on a monthly basis. They'll be retained in our records until the data process is completed, probably on a three month basis. In the absence of a report from any hospital, the institution will be contacted and asked if they didn't have any terminations or if they just ignored the report. Now, we realize that a great many women with interrupted pregnancy are treated in the physician's office and never go to a hospital. Later we probably will try to find some way of approaching the private physician on this sensitive matter. And I believe that your office has said when the committee meets again somebody will be there to discuss this problem from the Board's standpoint.

CHAIRMAN: Do you want us to take any action here today?

DR. OFFUTT: No, really. If anyone is really opposed to this, I'd like to know about it.

CHAIRMAN: This matter is accepted for information of the Board. Are there any other questions for Dr. Offutt while he is present?

DR. KERR: I would like to raise a question pertaining to the law for school teachers and school personnel with respect to TB tests. Is this to be an x-ray, can it be a Tine test, or what is required? It will make a lot of difference in the money which the schools will have to expend to follow this law.

DR. OFFUTT: One of the laws that was passed specifically said the Mantoux test, and two years hence in the next legislature, we will attempt to get this changed. Now for the law for school employees, the physician has the option now whether he does an x-ray or a skin test.

CHAIRMAN: Thank you. Dr. Offutt.

DR. GLEN RYAN, chairman of the Board of Blue Shield: My report will be rather short but not too sweet. Blue Shield has been in a lot of messes but the one we are in at the present time is probably the greatest we have ever had. I am referring to the payment of claims. Now we expect this problem to be improved within the next few weeks but it is going to take some time to clean up the backlog as the system is entirely new in handling and processing the claims from the beginning of processing to the writing of the check. Once we have the bugs out of the system we feel it will be much better than the old manual method of processing claims. I would also like to announce to this group that negotiations are under way on the welfare contracts but nothing definite to tell you as yet.

Dr. Ryan stated it was announced at the Blue Cross Board meeting on Thursday that the Governor had written to Mr. Spring and Mr. Kilborn notifying them they were the intermediaries for Medicaid.

CHAIRMAN: Thank you, Dr. Ryan.

The chairman then called on Mr. Dian for any message he might have for the Board.

MR. DIAN: Mr. Chairman and members of the Board. I am here today to report on the activities of the Student American Medical Association at Indiana University during the past year and also share with you some of our plans for this coming year and also share with you some of our ideas on how the students, the prospective physicians of this state, may work more closely with organized medicine of the state.

First of all during the last year we had general meetings, for which you so graciously let us use the basement of your headquarters. We had such topics as abortion; we were involved in the social aspects of medicine and how it affects the physician in his judgment; also a program on euthanasia.

Probably the most significant thing, and the thing that you probably would want to know the most about, occurred last year. That was the organization and actual opening of our Southside Community Health Clinic Corp. This is an outpatient clinic on the near southside of Indianapolis which was opened in January of this year to provide care for the indigent people of that area. Now we limit ourselves to a neighborhood of approximately 8,000 and although there is some homogeneity in this community, the majority of these people are, in almost all senses of the word, indigent. We are open four hours a day, three days a week—that's in the evening, six to ten. There are usually two licensed doctors present. Occasionally, only one.

Junior and senior medical students are actually the first hand physician, supervised by the licensed physician. We presently have 42 licensed physicians who donate time to our clinic. They donate four hours once a month or once every six weeks. There are over 200 medical students involved in some aspect of our program. We also have medical technology students and students from the school of medicine library sciences set up our record keeping and all of our forms. We have a laboratory where we can do most routine blood counts. We have a medical technician there to do smears, etc.

We have, in a sense, a working agreement both with General Hospital and with Methodist Hospital on referral. Many of our more sophisticated tests are done by General Hospital. We charge a dollar per year for membership for the family and we charge 50c a visit. Most of our drugs are given free to the patients. Twenty-two pharmaceutical companies have donated approximately $22,000 in pharmaceutical products and these of course we received at no cost and passed on to the patients at no cost. One thing I didn't mention and probably should have is that this clinic is governed by a board of 15 members, ten of which are community people who actually live in this community. The other four are medical students and the fifth is a staff member from the university. I should also say that we have the approval of the school of medicine and of the Marion County Medical Society for our activities.

DR. GOSMAN: I happen to be a faculty advisor to this group. To the best of my knowledge, what they're seeing down there is presumed to be a good cross-section of general practice, things from thorns in their fingers to colds, pneumonia, to intestinal complaints, to one lady with a broken back.

MR. DIAN: To continue now with what we propose to do next year, the first thing we propose to do is have a booth at the Indiana State Medical Association convention in October. This booth will be primarily a place in which practicing physicians will be able to meet some medical students to learn about SAMA, to learn about the so-called new radicals, the new Turks, to see that we're not too much different than you were when you were in school but we have some ideas that we think are good and we're trying to push this one thing.

Second, we're planning to continue our meetings and many students are very concerned about the so-called practice of medicine. The threat that the way medicine is practiced today may not be practiced tomorrow and most students have not taken sides yet. We plan to present both sides of the picture on how the delivery of health care is going to have to change and why. These items are major goals in our meeting to try to express both sides of this question because we feel to be effective medical people in evaluating this change, we have to be knowledgeable on both sides of the issue.

We are happy to continue our association with the commissions of the Indiana State Medical Association. Although there probably has been some lack of attendance on our part, there are probably several reasons which I don't know, we feel that this is still worthwhile. It's worthwhile in that medical students are able to receive some education in organized medicine. Most medical students don't really understand that this is one way of implementing this.

I was asked not too long ago about what is the place of SHO in the Indiana University and I said that SHO is really not a threat to Indiana University yet, although as new young liberals who are fresh from the undergraduate schools make their presence on a medical school's faculty, there will probably be more action on medical school campuses. There is more and more interest in the new left ideas of SHO. But I think SAMA is not threatened very much at Indiana University because we have these programs and not only the clinic, which in a sense is an SHO innovation of about six years ago, but as far as this being a real threat, I'm not concerned.

Now with SAMA, as far as making a stronger and closer relationship with state medical organizations, I feel as I said before, we should continue to meet with the commissions. I plan at all of our meetings next year to invite as many practicing physicians as we can. The medical students really have been deprived of their relationship with the practicing physician. If at the end of meetings they could talk with him for a half hour about how he handles this or that, or you know, like where you send your abortions in the state of Indiana. Just little things like this would be very helpful. No, I mean this sincerely, this would be the type of thing

students being in the university setting do not know and are not able to find out.

The most important thing I can say to you gentlemen today is that I feel that some mechanism, some means should be made in which the student may have a place in your House of Delegates. Now you may think this is being rather presumptuous of us but I don't think so. The first thing I think is that most students or all students have an equal stake in the practice of medicine as you gentlemen have. We have a stake in what is being done now and what is being said now because we will be around to either reap those benefits or fall under the yolk of whatever comes. I also think that there is a logical way the medical society can stem some of the disruptions that have occurred in organized medicine, like letting the medical students participate in your organization and see how it's done, before they become specialists and in specially-oriented groups. Again, basically it would be an educational thing for us. We probably wouldn't be able to contribute in many aspects because of our lack of knowledge and our lack of experience in the process. But in other issues we possibly could lend a new light and a new viewpoint.

I'm sure that you are all willing to listen to someone who has been practicing medicine as a colleague, just as you listen to other gentlemen speak and give their ideas. I think that you should consider this in some way and consider how this can be implemented. I read in the daily news not too long ago that the state of Colorado medical society now will be considering in September a resolution to get all students into their membership and to give them a voice. I think this really should come under your organization too. That's all I have to say. If there are any questions, I'd be glad to answer them.

Mr. Dian's remarks were discussed and several questions asked concerning the attitude of students and teachers at the university level.

The chairman then introduced Dr. Robert Stonehill, coordinator of the Indiana Regional Medical Program and asked for his report.

DR. STONEHILL: As I am sure you are aware, our program is operational. It has been in operation since January and we now have five programs going in the state. Our program calls for a review at least three times annually to evaluate the progress of our programs.

The Coronary Care Committee has been extremely active in dispatching some of our cardiologists as consultants to some 20 hospitals who sought their advice. It is apparent that one of the needs in our state is that of cardio-technicians and we are very shortly planning to start a training program for physicians on Wednesday afternoons and evenings at Marion County General Hospital. Teams which we now have in the field consist of occupational therapists; physical therapists; speech therapists, and nurses who are now going to hospitals. They have covered some 25 hospitals on invitation to look over the program as it relates to prevention, cure and rehabilitation. Our program also provides training for these people so that they can go back to their hospitals to help them set up their programs at the local level.

The review committee has completed the review of some 2,600 cases. The first 1,300 cases analyzed brought forth some very interesting figures. I did not bring them with me, but in roughly 62% of the people screened, an abnormality was discovered. Approximately 80% of these who were found to have an abnormality, only about one-half of them had visited a physician prior to this examination. What we don't know yet, as these figures are coming in slowly, is exactly what they mean in the way of preventive medicine.

This coming week we plan to open a second clinic in the Martindale Health Center and I and other physicians are involved in training a new group of technicians. The Metropolitan Health Council has opened three clinics, two of them operated by the Methodist Hospital and one by the Marion County General Hospital. They are busy developing this neighborhood clinic concept and I think you will be pleased to know they have told us they will not come back, after this one year's trial, for federal funding. They feel that once they have proven themselves, local funding will be available and I think this is true.

The feasibility of a centralized tumor registry of the state is going on. Unfortunately, I don't think this will probably be continued into an operational study. It has shown many problems. It showed some progress but I think the feasibility aspect of it is going to show that probably we are not going to be able to continue this program.

We have many new proposals that have been worked up and developed and I would just like to say one thing about the proposal that I think is important. Our complicated method of reviewing proposals became so complicated that it discouraged people. We now have a new method by which if an individual has an idea, if he will just write a one page summary and send it to me, I can then make a judgment as to whether it falls within the realm of reasonable medical programs. Upon deciding it is within the realm, I will assign one of my staff to work with this individual. In addition, we will refer this matter to the appropriate health agency. In other words, we will make up a team to work with the proposer to help him in developing his proposal.

We feel that the advantages are: (1) my representative can help make certain that the proposal is put in an acceptable form; (2) that the various health agencies can add whatever know-how they have to help make the proposal wider in acceptance and when it is worked out and sent to us we will send it out to the scientific advisory committee. The advisory committee in turn will designate a group who will review the facilities and the program and in the meantime we will question very thoroughly the reasons for the proposal. This will be the first time the proposer will have a critique on his application.

The next step is approval by the executive committee. We had our last executive committee meeting last Wednesday and there were six proposals presented, all very thoroughly worked out, four of which will be recommended for approval and two of which will not be recommended. So I want you to realize that everything we receive is not approved and yet we are trying to develop a method in which the people in the state have adequate assistance. I would like to ask Dr. Gosman to make a few comments concerning this program.

DR. GOSMAN: I would like to elaborate on this just a little. Now the first thing, Dr. Stonehill, is that most of the men do not understand that this is not a part of Indiana University but that it is a separate organization which happens to be housed at Indiana University. I do not think there is any group more aware of the fact that there is a centralization and there has been a lot of talk about taking it off the campus. In fact, our next meeting will be in the ISMA. We hope that this will help underline the fact that this is not a university project and so we will attempt to meet away from the university setting.

A couple of other points I want to make is that there was some question concerning the fee that the university charges the foundation. Let me answer that in this way. I think if any of you would see the amount of time, and effort, of the knowledgeable people who help prepare these things that we could not do this without them. I don't know of one of us around this table who has the time to do this and for the amount of handling and assistance, I think the charge is reasonable. I also want you to know that this is all an

attempt to dovetail this program along with our continuing medical education program through the university. I don't think anybody has to think twice that money is tight. Mortgage money is becoming tight and the university does not function on what the legislature gives them. A certain portion of this money may be used in compensating some of these people for what they really do. We are trying to involve more people in this and to educate them as to what is really going on, what can be done in their community.

For instance, there is a breast examination program in Lake County, and four or five other counties have all agreed to become involved in similar programs. So one of our real purposes is to try to get doctors involved. If we here at the state level really understand what we will try to do is get the public involved in these areas and to disseminate this knowledge and not keep it here in Marion County. What we are asking is that the state medical association approve of us going out and trying to get our doctors involved in helping the university in continuing medical education programs where we can all be benefited. As you and I know, we always say that the doctors must be involved. This is a real place of involvement and I think we can really make a great step in approving this program.

The comments were further discussed by many. There being no further questions the chairman thanked Dr. Stonehill for his presentation.

The chairman then called to the attention of the members of the Board a publication for their use as an index to the authorities, responsibilities and duties of the Board of Trustees of the Indiana State Medical Association suggesting that it be kept in their files for ready reference.

Report of Officers

CHAIRMAN: We will now proceed with the reports of officers. Dr. Corcoran.

DR. CORCORAN: Fellow officers, members of the Board, and guests. As you know, I have appointed an Advisory Committee on Health Care. An initial meeting was held. Doctor Steen, Mr. Waggener and I attended the first meeting for a very short period for the purpose of launching the work of this committee. Since that time we have detached ourselves from the deliberations of the committee, giving them an opportunity to work in complete freedom. I have been most gratified to learn the committee has held its second meeting and there was total attendance of the group. They have scheduled a third meeting and it appears that this group is really getting their teeth into some of our problems. These are all very prominent individuals and I understand they are taking quite a constructive and serious interest in the subject. I am most hopeful that we will have some report from them by the annual meeting. Frankly, I had some anxiety and misgivings about whether this project would be worthwhile and how it should be handled but as of now I am persuaded to be optimistic.

I would like to report that the officers and appropriate members have made two trips to Washington. The first being the Public Affairs Workshop in May and early this month the Executive Committee and three members of the Commission on Legislation made our annual Congressional visitation. I feel we have very good rapport with our Senators and our Representatives. It was a bi-partisan get together and I think we are making continued progress with our members in the Congress.

I would like to also report to the Board that I have prepared a letter to go to the presidents and secretaries of local medical societies, asking them to send in names of non-members who they would like to become members of their societies. As soon as these are received, I plan to write each of these individuals, encouraging them to join their county medical society, state medical association and the AMA. I also plan to write a letter to our members who, for one reason or another, have not paid their AMA dues this year. I also plan to initiate this year a report from the president, and I have requested the president-elect to prepare a report for inclusion in the House of Delegates' Handbook, rather than wait for the House to hear the remarks. I feel that the delegates should have an opportunity to consider some of the comments of the president and the president-elect prior to the meeting.

With regards to the annual meeting, there are several items I would like to discuss. The Trustees' Dinner is to be held on Monday Evening, October 13. While in the past this has been limited only to trustees and alternate trustees, I would like some specific guidelines from the Board as to what guests to invite, if any, and which officers are to be involved—whether or not we can consider past presidents, and the format of the meeting. This is our third get together of this type and it will be a formal affair but the wives and guests can have long or short formals. If you want something in the way of entertainment, please let us know.

Next, I would like to try to persuade the trustees to consider some type of organized social activities on Thursday Evening, October 16. The reason for this is we have the Indianapolis Symphony scheduled to play for us at about 8:30 that evening in the Murat Theatre. We do not plan a charge for this program but inasmuch as the theatre seats over two thousand people we propose to make tickets available to members, to give them to those who they wish to bring. The reason for this idea of a formal organized evening is I believe it would encourage promptness in arriving at the theatre and, perhaps, most important, it would give the trustees an opportunity to try to get the members of their district together for a sociable dinner hour prior to the concert. I would like to suggest that you give some thought to this idea.

The third item I would like to propose that you consider a couple of things neither of which will have any impact upon me or Dr. Steen, but I would like to try it out for size with you. I would like to suggest that we consider letting the president designate the chairmen of the commissions. All of you who have served on the commissions understand how sometimes a selection of a chairman has been rather impromptu and at times unsuccessful. This is an academic point for me but I think that the president would probably be able to designate a chairman who would more effectively carry out the projects that he would like to have done for that particular year during his term as president. I would like to suggest this to the Commission on Constitution and Bylaws for consideration by that commission.

Another matter has to do with something we talked a little about last night and that is making the House of Delegates knowledgeable as to the performance and to the job which is being done by various people whom they elect. There are a number of ways to do this. Some people think we should insist that for every office the House consider at least two candidates be presented in nomination. This is one suggestion. Another which Dr. Steen and I have discussed has to do with the consideration of a nominating committee. Dr. Steen has more explicit ideas on a nominating committee but I am taking the liberty of mentioning that this could not be singly appointed but possibly the House would designate a certain number—possibly the president—or possibly the Board of Trustees—and then the Board of Trustees could execute it through the Board itself. I have been toying with the notion that the House might be encouraged to establish a committee of its own, somewhat like the General Assembly does, an interim type of commit-

tee which reports back to the House. I would like to throw this idea out to you and if I don't evoke too much opposition, I might submit this as a formal recommendation for the House to consider.

I was glad to see several members of the Board sit through a part of the meeting of the Executive Committee.

Now, I want to get into a more delicate matter. I have been concerned, as most of you know, about the probable development of criticism of our profession with regard to fees paid by public agencies. As you know, the Senate Finance Committee has requested the administration of the Title XVIII program for information concerning fees paid to physicians. The point is we are not in a position to be alerted to these things at a time when they are subject to our doing something constructive in a prophylactic manner. Our colleagues in Wisconsin are in a different position. They are the fiscal intermediary of this program and they did, as you may know, take some action in regard to some of their members several months ago. I was talking to Mr. Kilborn, informally, several months ago and told him that we would like to know, whenever he could legally and ethically tell us, about any problems he might have in the administration of these public programs. I took it upon myself, also informally, when we were in Washington, to tell some of our Congressional representatives and the Senators that we are interested in knowing what the attitudes are and what they know about problems that they do not like and if they would tell us what is appropriate for us to know, that we would like to do the best we can in correcting any misunderstanding or malfunction of the program. Now, there are, of course, certain items and they are different. First of all there is the matter of fraud. This is the thing that will probably be the first to come under study. This, as I understand it, is a matter of legal procedure and would not be in direct purview of our organization. Over-utilization is, however, an abuse with which we would have some professional judgment. I think we must, however, direct our attention to the total fee structure. Now each of us knows what he is doing or what his close associates are doing with regards to the way they are charging but probably none of us really knows what other members of our profession are charging and to what degree these charges are arranged. Many services have changed—some deserve a greater reward than others; others have changed —have been simplified so that they may well deserve our re-appraisal. It is my own opinion that if we want to stimulate physicians to get into the front line of health care delivery that we must take a cold look—a realistic look at the rewards, the incentives, the recognition, the prestige, the working conditions. All of this, to me, is a very crucial matter, and I think it is one that is directly and primarily a professional function and we should not back away from it. I would like to ask the Board to authorize me to formally make it known to our Congressmen that we are interested in honestly appraising and evaluating any abuses, whether they are imputed or alleged abuses, over-utilization, or improper fees. If such information was received, I think we would have to follow through and make an honest evaluation of any such charges. I would like to make this known, formally, to Blue Shield and I presume when we get into Medicaid, it would also involve the welfare department.

I would like to urge again that the state association and possibly each county society, would have a committee, which for lack of a better name, I would call a Professional Standards Committee. This is not a Grievance Committee, as we have come to know it, which deals primarily with matters external to organized medicine. The Professional Standards Committee would be a committee which on its own initiative would not have to await formal, written charges and would intervene or look into alleged complaints that threaten the good name of any member of organized medicine or organized medicine as a whole. We have had some experience with this type of program in our own area and it has worked, we think, very well. It has real prophylactic value and many men can be helped and those who have been unfairly accused can be cleared before it gets to a point where formal action would be necessary.

The next matter I would like to discuss has to do with student health services of the major universities of the state. There are differences. I understand that at Purdue this is a non-profit function of the student organization; whereas at I.U. it is operated by the university. I have also been investigating a bit as to what is being done at the medical center. The directors of at least three of these services have shown a very real and very sincere interest in further pursuing the matter and I am setting up a meeting of them, jointly, during the coming weeks to explore this. I think we can do a great deal in strengthening our organization by encouraging these men by taking part in this and by opening a two way communication in making helpful suggestions. I look forward to this meeting being fruitful.

One final matter would be, of course, to follow up the suggestion of the president of the Student AMA with regards to our annual meeting and giving them means of having more formal access to the House of Delegates for presentation of their ideas.

Thank you, Mr. Chairman.

CHAIRMAN: Thank you, Mr. President. I think we have several things here that the president has requested us to act upon. First of all, the annual Trustees' Dinner. In the past this has been limited to the trustees, alternates, and the current officers of the association. The president has suggested that we might open this to others. What is the wish of the Board?

DR. PETRICH: I would like to move that we open the invitation to only the past presidents and not consider any other guests and that they should be subject to the same restrictions we are all under, that of paying our own way. The motion was duly seconded and carried.

CHAIRMAN: The president also made a suggestion that the president be permitted to select the chairmen of the various commissions.

DR. KERR: I will so move. This may require a constitutional change. If so, then I move that it be referred to the appropriate commission. The motion was duly seconded and carried.

CHAIRMAN: The third suggestion was the possibility of naming a nominating committee to recommend to the House nominees to the various offices, also some type of reports to the House on how the officers or trustees functioned during the previous year. I would assume this would include some type of report on attendance and participation. What is your wish?

DR. CORCORAN: Mr. Chairman, I think this is an extremely complex but a very important area and I would hope we don't make any hasty decisions. We must give it adequate time and think about it and concern ourselves with multiple alternatives before making any decisions.

CHAIRMAN: It seems Dr. Corcoran is not asking for any action. We will therefore delay this for future consideration.

CHAIRMAN: The next proposal was that we develop a plan which would place the ISMA in readiness to evaluate any alleged abuse involving fees paid to physicians for care of their patients under the various federal programs.

Question: How would you define "follow through"?

DR. CORCORAN: Well, actually under the Bylaws, the Board of Trustees is the

Board of Censors of this organization. Now whether complaints such as these should first come to the Board or the Grievance Committee seems to me might be one way of dealing with it or it might need to be referred to another commission or committee. There are a variety of ways or techniques that would occur to me.

The matter was further discussed by several and Dr. Corcoran said that the only thing he wanted to know is, do you have any objections to my formally asking for facts in any cases which might be called to our attention? Obviously this needs further study and consideration and possibly should come up many times for consideration. **On motion duly made and seconded, the idea was adopted.**

CHAIRMAN: Thank you, Mr. President. We will now go to the report of the president-elect.

DR. STEEN: Ladies and gentlemen, I've spoken to you many times about continuing medical education. I'm going to speak to you about it again today, but I have noticed that certain of our trustees are not interested in continuing medical education. Last night, a very devoted and dedicated group of trustees met and studied anatomy for a couple of hours at a local bistro, and I think the rest of you are remiss for not being present for this study. I have several unrelated matters to discuss with you, and I have some matters that I think are of extreme importance to this organization.

Excuse me, Doctor, excuse me. Would you say that what we saw last night was a pornograph? No. This was videotape from the medical center, direct from the dean's office. Mr. Waggener forwarded to the chairman of the Board, to the president, and to me, the *AMA Newsletter*, an outgrowth of one of our recommendations. Dr. Howard incorporates much excellent information in this *Newsletter* and I suggest that each trustee receive this bulletin also. The current one points out one very critical problem, of which we are aware—the physician shortage. It also has an economic message about how collections are on their way down. I believe this *Newsletter* has been quite a help in keeping communications open between the American Medical Association and its component organizations.

I recently had the privilege of attending a meeting called by the Council on Medical Service of the AMA on the subject of peer review. The meeting was held on Sunday in Chicago, and lasted eight hours. There were representatives of the Health Insurance Council, National Blue Cross and Shield; there were some governmental observers; and there were 18 physicians selected, more or less arbitrarily, from 18 different districts in the United States. I was selected to represent Indiana, Illinois, and Missouri. It is apparent that we, as an organization, must involve ourselves in the matter of peer review. We must not only involve ourselves in the review of fees, as they relate to the usual and customary programs, but we must involve ourselves, as Dr. Corcoran mentioned, through the utilization of procedure and the over-utilization and the under-utilization of procedures. I have said repeatedly in our own Fee Review Committee in Lake County that the utilization of a given procedure can be infinitely more important that the fee charged for a given procedure. I would strongly urge that the state medical association gather data on the programs that are operational in the state today so that we have information that can be imparted to other county societies who are interested in developing a review mechanism. I would further suggest that we strongly urge all county societies to get busy with peer review. I further urge that one of the Board committees or an ad hoc committee be appointed to investigate and evaluate the available material we have reposing in Indiana today so as to attempt to develop pilot programs and an educational program for all the physicians covering the validity and the value of peer review programs. I have written to Mr. Waggener and asked him to begin collecting data. I think we must get into this field! The AMA recognizes the necessity for being involved in this field, but I think it was quite clear in Chicago that this is an impossibility for the AMA to be involved other than on an educational basis. Fundamentally, this comes down to the local county medical society. Our function as a Board of Trustees of the state association must be a catalytic function rather than an actual "nuts and bolts" function.

Now what happens when you find that there are over-utilizations or gross immorality in the delivery of health service? This is the area that interdigitates with the subject Dr. Corcoran talked about. It's quite interesting that he and I came up with two different approaches to the same problem. I learned from Dr. Hunter, the past-president of the Washington State Medical Association, that Washington has a Medical Disciplinary Board, separate and distinct from their Licensure and Registration Board. This is a legally constituted body of the state of Washington composed totally of physicians. A physician is selected from each congressional district to be a member of the board. The physician who is elected to the board is selected by physicians only. The physicians vote by mail ballot and only those physicians who hold a valid license to practice medicine in Washington elect the members of the Medical Disciplinary Board. The board is assigned legal counsel from the Attorney General's office who works with them in the subpoena procedures. They have all the powers of the courts in the state to subpoena residents, to require information, and to delve into all the aspects of the practice of medicine. An obvious example of the benefits of involving ourselves in such a Medical Disciplinary Board is the example of the senile physician who does not function well under the direction of the hospital staff; one who does things that he really ought not to be doing and the hospital staff is unable to control him. They further know that there are things he does in his own private office that they have no control over whatsoever. Under this system, this gentleman could be brought before a Medical Disciplinary Board, who might recommend revocation of his license. In Washington,when the Medical Disciplinary Board recommends to the Board of Licensure and Registration that a license be revoked, it is not a suggestion; it is a mandate. The force of law requires them to revoke that license temporarily or permanently based upon the decision. I have written to the Attorney General of Washington and have a copy of the law. I have a copy of the *modus operandi*, and I have some other comments that I can pass on to the appropriate body who studies this problem at a latter date. I am not asking the Board to take any action on this today, but I think it is an extremely important area. I think it is one that deserves my favorite term "in depth study" and I hope to propose this to the House of Delegates in my address in October.

At our Board meeting in Chicago in March, I discussed with you one of the projects that I hope to activate next year; namely, "Health Week" or "Health Week for Youth" in which we propose to invite all the high school students in the state of Indiana to Indianapolis for two half days and one whole day. The president has permitted me to appoint a committee consisting of Dr. Corcoran, Dr. Taylor, Dr. Petrich, Dr. Steen, Mrs. Schneider, the president of the woman's auxiliary, and staff consisting of Mr. Bush and Mr. Waggener who are doing all the work. The committee has now met two times and have enough material to meet again in New York in a week and a half. Yesterday, our committee set the date for this projected program to be Wednesday, Thurs-

day, and Friday, April the 22nd, 23rd, and 24th of 1970. It is to be held at the fairgrounds where we propose to house the students in the dormitory out there. They will pay $1.00 for the use of a mattress or bring their own bedding. Those who wish to bring a sleeping bag will sleep free. Mr. Waggener is investigating the possibility of getting motel rates for schools who may want to send entire delegations on a bus. The auxiliary will be involved in this project to a great extent. Things are moving ahead very rapidly, and you will remember this Board approved in concept this activity and asked that we return to the Board at a later date with some cost estimates. We are now far enough along that it would appear that this will cost the Indiana State Medical Association about $12,000. I spoke to you previously about the concept of a gradual increase in the dues of the Indiana State Medical Association. I said to you before, and I say it again, that I believe this is the program that will fully justify the first $5.00 increase; and although it is not part of my formal recommendation today, it's a little preliminary pitch. This would generate about $20,000 which would help offset a portion of our increase and part of the deficit due to the increase in the cost of living. It would totally underwrite this program!

I spoke with Dr. Ryan after his address to us this morning about the potential of obtaining a sizable sum of money in the range of $25,000 from Blue Shield to videotape the entire program. They totally videotaped the program in Wisconsin. They also made tapes from the sound tracks without any video. Their tapes have been rebroadcast throughout the state of Wisconsin on virtually every radio and television station so that the tapes have been used in excess of a thousand times. They can be utilized in short 15 to 30 minute segments. High schools have requested them on a daily basis to show to assemblies and to individual classes on the various subjects that were presented during the health week in Wisconsin. I think this has tremendous potential for good public relations on the part of ISMA and in addition to PR, and even more important, is the benefit this will be to the youth of Indiana who participate in the program. I would hope the Board would find it in their black little hearts to appropriate the $12,000 that we are requesting.

I call your attention to the document that has just been distributed to you—my own comments on the Planning Commission of the American Medical Association. I would hope that each man in this room will take the trouble to read the original 60-page document and the summary. If you have not received it, I hope Mr. Waggener will send it to you. I think this is probably one of the most important documents that has ever come out of the AMA because it not only will influence each of us sitting in this room but every practicing physician in Indiana. It is going to have a profound influence on the present medical students and their peers. I do not think this is a subject to be glossed over lightly. I don't propose to be an oracle, but there are some things in that report that shake me to the quick. There are some other things in the report that are very good and when you take a broad view of what is in that report and correlate it with the report of the public relations firm, Phillip-Lesley and Associates, whose report is in the handbook of the AMA, and then when you consider these two reports with the report of Cresap, McCormick, and Paget that I commended to your reading much earlier, plus the comments of the Board of Trustees on the specific issues raised in that report; you can see that by working at this over a period of time and giving it our diligent attention and our thought, we can formulate a blueprint for the future that can circumvent many of the difficulties we've had in the past. We can assume a posture of which we can be proud and we'll have something to tell. We'll have something to offer instead of being against.

My last point is that many of us have sat around for long hours wailing and moaning and crying and complaining and gnashing our teeth about the session we have before the annual and the clinical session of the AMA. We have railed against the recalcitrants of our delegation. We have commented on their ineffectual operations at the AMA level. I think, gentlemen, it's time to sit down together in an executive session, either today or in the very near future, and put into operation some of the plans that have been discussed at the local bars and the anatomical study groups that we have from time to time. I strongly urge that we get going on this because I think our image in the AMA is important. I think we can be effectual. The Indiana State Medical Association is regarded very highly every place I go, and we're regarded highly because of the effort you gentlemen put into the operation of the organization and due to a top-flight staff. Thank you.

CHAIRMAN: One point, I think Dr. Steen requests the Board approve including in the next year's budget the $12,000 figure for the Student Health Week. This may fit in with some comments Dr. Wilhelmus will have later in the meeting, and it might be wise to defer that until that time.

If you want to defer, I would rather suggest that we think about the necessity to put that through the House of Delegates rather than the Board. That's a big chunk of money on a new program, and I'm afraid it may need to be justified. I intend to report to the House on the Health Week in my address to the House.

DR. KERR: But do you think this Board should authorize that kind of an expenditure?

CHAIRMAN: I don't think so.

DR. KERR: You could recommend it.

CHAIRMAN: I go with that.

DR. STEEN: I'll tell you, Dr. Kerr, I really hate to see this program go down the drain, and I think it can be sold to the House. I think we ought to put all the enthusiasm and force in that we can possibly put so that for a whim it doesn't get scuttled. I think this is one of the most important things we've ever been involved in.

DR. KERR: I'll agree with you.

DR. BOWEN: Mr. Chairman.

CHAIRMAN: Yes, Dr. Bowen.

DR. BOWEN: Do you suggest that all four grades in high school be invited?

DR. STEEN: Originally, my conception was that this be limited to the juniors and seniors; however, the auxiliary, who lives with these kids day in and day out, says that it's too late to target it to the juniors and seniors. Sure, give them a refresher course in what they ought not to have been doing and how they ought to change their ways, but also get to the ninth graders and tenth graders who perhaps haven't fallen into the pitfall. I think that this is a very valid suggestion.

DR. BOWEN: My calculations show you are dealing with about 200,000 high school students.

DR. STEEN: That's right. We can't handle that many; but if we have a preregistration technique, I think we can handle the number that will come in the first year. Now, the first year in Wisconsin had about 4,000 kids there out of a potential of something in excess of 100,000. This next year they anticipate 9 or 10,000 in attendance. You must remember that all of these young ones don't stay for the whole two days. Some of them will come in for a half a day the first day; some for the last half a day; some will come for the middle day; and some will stay all the way through. We know there are logistical problems, but we feel that if it is to be a valid program, we must target it to those who will benefit most from it.

CHAIRMAN: Any other questions con-

cerning this Health Week that you want to direct to Dr. Steen?

CHAIRMAN: Dr. Santare.

DR. SANTARE: It seems to me when we discussed this at the last Board meeting the financing of the program in Wisconsin, was, I would think, something about 90% covered by subsidies from Blue Shield, and we're now hearing the subsidy should be from the state medical society.

DR. STEEN: That's wrong, Dr. Santare. In Wisconsin the state medical subsidizes the entire program. They have co-sponsoring organizations who help with publicity and other related areas. The only money they got was from Blue Shield. They got $25,000 from Blue Shield to make TV tapes and movies of the meetings. And they made the basic program a budgetary item because they think the program is so valid.

CHAIRMAN: Dr. Butler.

DR. BUTLER: I'd like to speak on the value of including the lower grades. In a study done here it was found that high numbers of kids were interested in health careers in the first year of high school and then something happened to them in the succeeding years; in fact they all wanted to become something else.

CHAIRMAN: Dr. Petrich.

DR. PETRICH: I would like to comment about money. I realize that that's a lot of money and yet, as discussed yesterday, we got along quite well and we're getting down to specifics. The problem with planning a program like this involves the paying of speakers of quality and caliber and interest and so on. And this is not something that can be done just out of the hat. So somewhere along the line, we're going to have to make a little salve to our conscience and proceed on the basis that we can recommend strongly enough and influence strongly enough the House of Delegates to support this with money. Otherwise we'll be up to the middle of October or later before we have any speakers down on the list for sure that we can say well, we're going full steam on this. Reserving the area on those dates is going to cost some money and I would hate to have to wait until after October and then cancel the whole thing out because there's no support for it. Somewhere we're going to have to make a compromise.

CHAIRMAN: I'd like to defer discussion of this budgetary item until Dr. Wilhelmus makes his financial report. I think we can discuss it as a package and will save a lot of time. Is there anything else that you would like to ask the Board?

CHAIRMAN: Yes, Dr. Steen.

DR. STEEN: One more thing, Doctor Taylor. Within a week, with the help of Mr. Waggener, I have prepared some forms to evaluate commission members. These forms will be sent to you. What I basically want is to make evaluation of the members of the commissions easy for you this time. The form will list the year their term expires, whether they are or are not eligible for appointment and their attendance at the meetings so you know how many meetings they have attended out of those held. I have devised a simple grading system by which I would ask that you grade the members from your area. Now when these arrive, will you please give them your attention and send them back so we don't have to bug you and beg you and twist your arm to get them. Really, it's very simple; it will take a few check marks and a couple of phone calls. I don't think it would take more than 20 minutes of your time and I wish you'd do it because it's a virtual impossibility to make commission appointments without the background information. Certainly I don't know all 4,000 physicians in Indiana. I wish I did but I don't.

Question: Are these confidential?

DR. STEEN: Absolutely confidential. It will only meet my eyes.

CHAIRMAN: Neither of our treasurers are present today but the treasurer's report is in your folder and I would ask you to look it over and if there is any question we can take them now or later. **On motion duly made and seconded, the treasurer's report was adopted as printed.**

CHAIRMAN: We will now ask Dr. Ramsey of *The Journal* for his comments.

DR. RAMSEY: Mr. Chairman, gentlemen. You will notice in the treasurer's report that *The Journal* at the end of May, before we paid our printing bills for the June Roster number, had $6,000 and some on the good side. This will shrink when we pay for the big month of June and another big month in September.

I have not yet been able to obtain from the tax lawyer or our auditors an idea about how we should calculate our advertising and text materials for tax purposes. The State Medical Association of California has been going through a tremendous financial review of all their finances and there is one sentence in a letter which was received from California which I think is significant. They said "We have carefully revised our publication bookkeeping system so that we can segregate accurately all the expenses of producing an advertisement in order that we may charge that against the advertising revenue." It seems at this point that we will be converting 50% of our income to taxable income and if so, this is going to make a considerable difference in our operation budget. I am not sure that we can continue to publish *The Journal* without either subsidizing the deficit now or at the end of the year or increasing the amount that we take from our dues because a certain portion of our advertising revenue goes toward producing the scientific portion of *The Journal.* This of course we won't know until we get the recommendations from our financial people and Mr. Waggener says they are scheduled to be with us in July for a discussion of this matter.

CHAIRMAN: Thank you, Dr. Ramsey. Any questions or comments?

Matters Referred by Executive Committee

CHAIRMAN: We will now take up the matters referred to the Board by the Executive Committee. The president, in the absence of the chairman of the Executive Committee, presented the report of the fees paid legal counsel during the previous month. Dr. Corcoran also stated he had been concerned about the amount of funds involved in the numerous medical legal cases which are in litigation and that the matter could get entirely out of hand over a period of time. He stated we do not currently have a monthly report as to the amount of legal fees owing for these cases and if this is so he would like to be on record that he would like a monthly report of what fees the various attorneys are obligating us to. I think we should come to grips with this matter as this is an area that already costs a lot of money.

CHAIRMAN: What do you want, Mr. President, something specific?

DR. CORCORAN: I think we ought to have some kind of technique of permanently keeping abreast of what we are becoming obligated for.

DR. KERR: I move that the Executive Committee submit a report to the Board of Trustees each month relative to this expense. The motion was duly seconded and carried.

DR. CORCORAN: May I offer as an additional motion that we investigate those cases where the Medical Defense Fund is used with the idea in mind of finding out whether or not these particular people have a malpractice carrier with which they are insured and if they do have, why they are not utilizing the facilities of the carrier as opposed to the State Medical Association Medical Defense fund.

Comment: I thought the availability of this assistance was one of the virtues of membership in the association.

CHAIRMAN: Mr. Waggener, do you

have any comment concerning this question?

MR. WAGGENER: Several years ago the question was brought before the Council as to whether this service should be discontinued inasmuch as most companies do provide their own legal counsel. There was some feeling that the association, in financing additional counsel, was duplicating the cost. However, at that time the proposal was turned down due to the fact that some felt this was a benefit of membership and the fact that the member would prefer to have an attorney of his own choosing rather than accept only the attorney provided by the insurance carrier who they might not know.

The motion was made that an investigation be carried out of those cases which are now in litigation. The discussion continued with the comment being made by a member, who has had the experience of being sued for malpractice, who stated that he did not have a private lawyer but the lawyer for the malpractice insurance company does not represent you, he represents the company and there are circumstances which arise in which the need for a private lawyer is not only advisable but necessary. The motion was discussed further.

CHAIRMAN: Gentlemen, let's ask for preparation of a report on this and become more knowledgeable about the thing and carry it over for another meeting of the Board, and then have it reported back at the next meeting. The motion was seconded, put to vote and carried.

The matter involving a physician in Lake County as it relates to the services of legal counsel and their charge for their services was discussed. **On motion of Dr. Santare, seconded by Dr. Gosman, the Board approved for payment of legal counsel by the state association rather than Lake County inasmuch as it involves physicians throughout the state. The motion was put to vote and carried.**

The second item referred to the Board by the Executive Committee was the matter of the driver's examination form. We particularly felt that the statement carried on the Alabama form was better than that carried on the Indiana form. The Alabama form states clearly "the determination of the ability of a patient to drive was vested by law in the Motor Vehicle Department of their state."

CHAIRMAN: The president suggests that we refer this to the Commission on Medical Economics and Insurance and also to the special committee of the State Bureau of Motor Vehicles which worked on this before and with your approval, we will do so.

DR. CORCORAN: I want to call your attention to a motion adopted by the Executive Committee regarding comprehensive health planning. It reads as follows: "The Executive Committee recommends to the Board that the field men who are dealing with the field of Comprehensive Health Planning be assigned to the headquarters office and that the Board committee, through the Board, and with the approval of the Board, make policy but the administrative control of these two employees be under the direct supervision of the president and the executive secretary." I would merely say that I find this is a good reason to encourage those of you to attend some sessions of the Executive Committee. The idea is that these two men are working down in the Blue Shield headquarters office and they are doing all their work and they have a telephone separate from the association. There is a dichotomy and the Executive Committee felt that the Board should reconsider the matter and these people should be brought into closer physical contact with our headquarters office and more direct administrative control of their day-to-day operation but that the policy and direction would be at the discretion of the Board.

CHAIRMAN: What action do you wish to take on the recommendation of the Executive Committee? (This matter was discussed by several.) You will recall that this matter was discussed at great length in Chicago and again at the Holiday Inn. What Dr. Corcoran talked about has become more apparent as time goes by. At the Holiday Inn the Board action, as I recall, was that the Board committee would continue to function and direct the men but all these men would report to the executive secretary as to what transpired and what was going to happen. The matter of reporting was discussed by several.

DR. STEEN: Mr. Chairman, I feel there is a very fundamental issue at point and I think we have to go back a little bit and recognize that when we organized the Board committees it was an effort to better organize and streamline the work of the Board. It was felt that these committees could do the research and study and report their findings back to the Board so the Board, as a whole, would not have to spend time in making this study which would therefore enable the Board to make intelligent decisions through the advice of the committee. The Board of Trustees cannot, in my opinion, delegate their responsibilities for decision making to a committee of the Board. This committee should be reporting to the Board regularly and the Board, as a whole, ought to be making policy and making decisions. I do not have any quarrel with what has been done as long as it is effective but I think there is this broad principle that a committee of the Board has in some instances taken it upon itself to take positive action, I say, without full knowledge, consent or assent of the Board. If I am wrong I ask to be corrected. I do not believe six people of the Board can take the total responsibility of the Board without consulting with the Board. This is not the way the other committees work. Likewise, the liaison between the Executive Committee and the officers is through the chairmen of these committees and through the chairman of the Board. The chairmen of those committees, such as the Fiscal Economics, Membership Review and other committees are not Dr. Corcoran's chairmen, they are Dr. Taylor's chairmen, as chairman of the Board. We have to work through the chairman and the chairman is distressed by the fact that unilateral type action has occurred by this committee. I think the activities they are engaged in are commendable. I am not arguing with that point. I am arguing with the principle of the thing and we have gone around this area a million times and we never get down to the fundamental principle.

DR. CORCORAN: I would like to support Dr. Steen's comments and further comment that I do not believe anywhere in the Constitution that you can justify a committee of the Board undertaking the executive activity for the Indiana State Medical Association and that is exactly what is being done here. I think that legal opinion would say that a committee of the Board does not have this privilege under our Constitution and Bylaws but this is a function of the president and the executive secretary. The matter was further discussed.

On motion of Dr. Gosman, seconded by Dr. Dukes, put to vote and carried, this matter is to be taken to the committee for discussion with the chairman of the Board and the Executive Committee.

Further comment was made that the Board has created a problem for itself by going out to get someone else's funds to do our work for us, and that we can well learn a lesson from this experience. In the future if we have something to do and need manpower to do it, that we hire them ourselves. Another comment was that these men do not represent the Indiana State Medical Association. They belong to Blue Shield and no one is

going to let us forget it.

DR. STEEN: There is another matter discussed by the Executive Committee which was referred by the committee to the Building Committee but since we are sitting here suffering today, I would like to throw it out to the Board hoping that we may shorten the time in which we can get this problem resolved.

As you are aware, the situation today is the failure of the air conditioning system which has never worked properly since the building has been occupied. Mr. Waggener has called out some experts in the air conditioning field and I think they are absolutely right that our system is a tailor-made system designed by an architect for this particular building. It is a water cooled system which does not function too well when the humidity gets too high. This causes crystalization of the refrigerant and keeps you from getting any cooling power when this stuff chokes up. It is an abortion of a system. The problem is that this system was built into the building and it is not easy to get rid of the current unit.

The only thing that can be done is to move the current cooling system outdoors and substitute an air cooled system rather than a water cooled system. The current pipes and ducts and controls in the building can be used. The only other addition, other than a unit, is the installation of a three phase electrical system which is an insignificant amount of the total bill.

Mr. Waggener has a bid from the Trane people for something slightly in excess of $15,000 to change over and convert the present system to an air cooled system. I told him last night I thought he ought to get a couple of other bids as I do not think we should accept one bid. I would like to ask the Board today, if after the other bids are in, we could expedite the activity of the Building Committee and permit the Executive Committee to make a decision about what could be done and if they decide to choose that we have another air conditioning system installed, would the Board today be willing to appropriate funds out of the building fund in order to make this change so we do not go the whole summer with a malfunctioning air conditioning system.

On motion duly made and seconded, the Board approved the Executive Committee proceeding with obtaining bids and signing a contract for the installation of a new system.

Economic and Organization Matters

The membership report was reviewed and accepted as printed.

Remission of Dues: On motion of Dr. Bowen and second by Dr. Wilhelmus, the dues of a member of the 13th District were remitted.

The next item was the nomination of two members of the Editorial Board for a three year term ending December 31, 1972, to succeed Dr. Jack W. Hickman of Indianapolis and Dr. Frank H. Coble of Richmond, Indiana. The matter was discussed and it was felt that perhaps a committee should be formed to investigate and make recommendations at the October meeting of the Board for re-election or replacement of these members.

CHAIRMAN: Now we have a matter of election of two members to the Trust Committee of the Indiana Medical Education Foundation for two terms ending October 31, 1972. The term of Dr. Donald E. Wood of Indianapolis expires October 31, 1969 and Dr. Roy Geider, the same date. **On motion of Dr. Gosman, a second by Dr. Santare, Dr. Don Wood and Dr. Geider were re-elected for another three year term.**

CHAIRMAN: We will now discuss item K-3, a resolution on the Regional Medical Program. Is there any discussion?

A series of amendments were proposed and accepted.

The resolution was adopted as amended on motion of Dr. Kerr and a second by Dr. Gosman.

The resolution is as follows:

"WHEREAS, there is a viable Indiana Regional Medical Program in operation the last two years with the Indiana University Foundation as the fiscal agent, and,

WHEREAS, a number of operational projects now have been funded in the Indiana region through grants made under this program, and,

WHEREAS, the process of regional cooperation begun by the Indiana Regional Medical Program offers many opportunities throughout the state for active involvement by practicing physicians as well as all components of the regional health care community, and,

WHEREAS, three presidents of the American Medical Association and several state medical associations have endorsed the concepts and the purposes of Regional Medical Programs and their goal of bringing about reductions in death and disability from heart disease, cancer, stroke and related diseases,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association endorse the concept of Regional Medical Programs in Indiana because it is medically oriented and is one of the few federally financed programs that gives initiative to people at the local level,

AND BE IT FURTHER RESOLVED, that the Indiana State Medical Association encourage member physicians to support Regional Medical Program and to help determine ways in which they and agencies and institutions with which they are affiliated might become involved in this broadening regional cooperative arrangement."

CHAIRMAN: We will now move to item K-4 for establishment of a Speaker's Bureau at state level.

DR. PETRICH: I would like to recommend that the association establish a speaker's bureau at a state level using the group who took the course in Chicago as the nucleus. **Everyone I spoke to seemed very much in favor, therefore, I move that we establish on a formal basis an Indiana State Medical Association Speaker's Bureau composed of geographically distributed physician speakers; that the nucleus of this group be the Board but this does not preclude inclusion of other eloquent, knowledgeable speakers, and that such information of the existence of this group be submitted to schools, churches, service clubs, etc.**

The motion was duly seconded and carried.

CHAIRMAN: We will now move to item K-5 on the combined meeting of the AMA Council on Voluntary Health Agencies and the Indiana State Medical Association Commission on Voluntary Health Agencies. Mr. Waggener, will you please explain this?

MR. WAGGENER: The AMA Council on Voluntary Health Agencies is planning an eleven state regional meeting in Indianapolis on Saturday and Sunday, October 11 and 12. Dr. Dorman, president of the AMA, will be present as well as several dignitaries of the council. Also there will be representatives of state medical associations from these various states. The AMA council has requested that the Board of Trustees of the Indiana State Medical Association be invited to attend their annual dinner which will be held at Stouffer's Inn on Saturday night, October 11. Also we have agreed previously to pick up the tab for the reception for some of these people before the dinner on Saturday evening. You will, however, in the future receive a formal letter of invitation but they have requested that we determine if the Board will accept their invitation to meet with them at that time.

On motion duly made and seconded, the secretary is requested to advise the AMA that the Board would accept their invitation.

CHAIRMAN: We will now receive the report of the ad hoc committee of the

Board on re-districting of the Indiana State Medical Association.

DR. KERR: I will give you a preliminary information report for your consideration. You are all familiar with the multiple ramifications and I think most of you are familiar with the origination of the agitation for re-districting and I know there are many arguments about that. You all know that the state and insurance commissions, its committees, the Blue Shield Board, are all fairly well tied to our present district set up. Rather than go through hasty action of re-districting the whole state, I would suggest to you that we consider this as a possibility—mind you as a suggestion—the whole committee has not yet met, I was appointed only this past week, but for your consideration, make Marion County a 14th district, giving them a trustee—and I have talked with people from that area who think that would be acceptable—leaving the remainder of the 7th district as it is with a trustee in that area, leaving the rest of the state the same, and let the Commission on Constitution and Bylaws and the Future Planning Committee make additional changes as we go along.

CHAIRMAN: Obviously we need take no action on any statement Dr. Kerr has made here today but the suggestion has been thrown out for your consideration and opinion. This matter was discussed by several.

CHAIRMAN: In the interest of time, let's contact Dr. Kerr by letter, by phone, or what have you, with any ideas you might have.

Reports from Commissions and Committees

CHAIRMAN: The report of the commissions and committees have been mailed out so that you all have the opportunity to read them. There are some we need to consider here.

Commission on Public Health: (a) Commission suggests that the law regarding tuberculin testing and chest x-rays of all teaching personnel be distributed to all physicians in Indiana with the recommendation that a follow-up of all positive tests and chest x-rays be made.

(b) Drug Abuse in Indiana—commission recommends a statement be carried in the next *News Flash* incorporating the following idea:

That a definite effort be made by ISMA to make local county medical societies aware that schools are required by state statute to offer drug education to all students in grades 4 through 8 and it is *mandatory* that all schools provide drug education courses in the grades 9 through 12. This, however, is an elective as far as students are concerned.

This commission urges that local medical societies stimulate the local school superintendents to implement this law effectively and urges that local medical societies offer physician participation in these programs.

By consent it was agreed no further action was necessary and that these recommendations be published in the News Flash.

CHAIRMAN: Are there any matters in any of the reports that anyone wants to bring up at this time?

DR. SCHOEN: I would like to discuss the Commission on Emergency Medical Services. The commission requests in view of the resolution which is being taken to the AMA meeting in New York that an emergency amount of $50 be provided for printing of materials to support this resolution. The commission wishes to take to New York small reproductions of the sign that the commission has suggested for use in indicating the location of emergency medical services. We have a quote of approximately $50 for printing these. **On motion of Dr. Santare and a second by Dr. Bowen, the $50 was allocated.**

Board Liaison with Blue Cross—DR. TAYLOR: Last year for the first time since '56 or '57, Blue Cross operated in the red. They lost some three million dollars that year. In the past year they have operated on the premise that costs are increasing at about 8% per annum. They are now having to change their thinking and projection and are now going to consider approximately a 14% per annum increase in hospital costs and this will be the basis on which their premium rate will be determined in the future. The matter was discussed by several and the comment was made that in the Methodist Hospital in Indianapolis, private beds are subsidizing Medicare patients at a rate of $4.00 per day. It was suggested that perhaps the Liaison Committee of the Indiana State Medical Association with the Indiana Hospital Association might consider issuing a joint statement concerning this fact. The secretary was instructed to check with Mr. TeKolste if such a statement from the ISMA would be helpful in explaining hospital costs.

Board Liaison Committee with Blue Shield—DR. KERR. No report at this time.

Board Liaison Committee with I.U. School of Medicine—DR. PETRICH. No report.

Board Committee of Business Consultants for The Journal—DR. DUKES. No report.

Board Committee on Economics and Fiscal Matters—DR. WILHELMUS: I have studied the proposed budget for this year and I am of the opinion that the association needs more money. There are two ways of getting more money and that is to raise dues or lower expenses. I believe we want to evaluate the amount of funds the association should have as a nest egg for unanticipated expenses and happenings. I think there is one area in which income should be sought and that is from new members and I would like to read a resolution which I have written and ask you your opinion on it:

WHEREAS, a majority of members are not donating $50.00 for the ISMA building, and,

WHEREAS, the majority of the members of ISMA realize that the building is an asset to organized medicine, and,

WHEREAS, time passes, and depreciation of the facilities of the building will be necessary,

NOW, THEREFORE, BE IT RESOLVED, that all new members of ISMA be assessed $10 per year for five years, beginning with their first membership year, and,

BE IT FURTHER RESOLVED, that this assessment will be carried in the building fund and all dues paid by members will go into the general fund.

I have written to the AMA and find that other states have the following assessments for their building program: Arizona has a $125.00 mandatory assessment of every member; Georgia has a $100 assessment per member; Idaho has a $100 assessment; Maryland has a $10 per year per member assessment for their building fund; North Carolina $125 per member. In most of these states everyone is assessed so much for their building so we are not asking for something unusual.

The resolution was discussed by many, raising questions on tax deductibles; need for funding of the depreciation; employment of additional staff; financing of additional programs, as well as present programs; and the natural objection to an assessment for any purpose; also that an annual dues increase would be preferable to any type of assessment. It was also pointed out that the association had an obligation of approximately $23,000 which had been loaned on an interest free basis for the association building. These loans might at some future date be called by the members. Also we are in an inflationary spiral and the cost of living is going up: expenses of computerized billing; attendance at the AMA meetings; etc.

The proposed resolution was lost for want of a second.

A motion was also made that the delegation to AMA meetings be limited to AMA delegates, alternates, the president, president-elect, immediate past president, chairman of the Board and the executive secretary. The motion was seconded and a motion was made to table the motion, and the motion to table prevailed.

Dr. Wilhelmus then continued his report, discussing the affairs of *The Journal* and the expense vouchers of staff members.

Board Committee for Orientation of New Members—DR. CLARK. We have a program that I think will be similar to the program we have used before but we have to find a place and a time to hold this meeting. The time, of course, will have to be worked into the convention program. As to the place, one of the new members of the committee has suggested that we should use the headquarters office building for this purpose, include in the invitational list the senior medical students and to have coffee and doughnuts for a breakfast type meeting. I think this is an excellent suggestion because we do have to have a time and a place set up for this meeting without further delay.

Board Committee on Membership Matters—DR. BOWEN. I would like to make a comment in regard to dues. I wrote the AMA in regard to state dues of the various state associations and find that Massachusetts has the least rate of $35 per year and Alaska has the highest of $200 and I have averaged them out and they averaged $86.35. Hawaii is $140, Georgia $140, North Dakota $125, Ohio $50, Illinois $105, Kentucky $80, Missouri $65 and Wisconsin $125. Concerning the matter we were mandated to do, regarding the survey of members, we mailed the questionnaire to the secretary of each county society asking them to distribute this to their membership. Out of the 4,444 members, 847 responded, which is only 19%. The report of this survey is as follows:

ISMA SURVEY RESULTS

The 847 responses to the ISMA survey were keypunched by one keypunch operator and verified by a second one. This procedure minimizes the possibility of keypunch errors in the data. I have made some checks on the results, but others more familiar with the study should make appropriate checks also. I felt that the typewritten report would be more useful than the detailed tabulations; however, these tabulations are available if required. Specific points about the tabulated report follow.

1) The "yes" responses and their percentages relative to the number of respondents for a particular question are tabulated. "No" respondents may be determined by subtracting the number of "yes" responses from the number of respondents for that question.
2) Answers to questions 1 and 28 were each lumped into the respective categories. If desired other combinations may be made.
3) It was assumed that a physician could be engaged in one type of practice only (question 33). The first answer checked by the respondent was the one used. If a different type of analysis is required on this, please let me know.
4) Two different methods of ranking priorities for question 34 were used by the respondents. One group ranked them as 1, 2, 3, . . . 11, 12. The other group assigned a rank of 1 to several different activities, a rank of 2 to other different activities, etc. The results tabulated were for the 9 highest priorities.

Membership Survey Summary
1968

Indiana State Medical
Association

Prepared by
the

Research Computation Center
Indiana University Medical Center

January 15, 1969

SECTION I — ISMA MEMBER SURVEY

Response Summary

TOTAL NUMBER OF SURVEYS IN THIS STUDY: 847
NOTE: percentages given below are in terms of the number of respondents to each particular question and are reported to the nearest percent.

QUESTION				NUMBER OF RESPONDENTS
1.	226	(28%)	members have attended no ISMA convention,	
	570	(71%)	at least one,	
	374	(47%)	more than two,	
	234	(29%)	more than five,	
	113	(16%)	more than ten.	796
2.	200		have attended a session of the ISMA House of Delegates.	844
3.	570	(68%)	know their medical society district trustee and	840
4.	558	(71%)	have met him.	781
5.	464	(55%)	sometimes read *The Journal of the ISMA*,	
	29	(3%)	never,	
	350	(42%)	regularly.	843
6.	644	(77%)	know of the Preceptor Program.	835
7.	517	(61%)	have attended AMA Convention.	845
8.	428	(51%)	know ISMA delegates to the AMA.	841
9.	246	(30%)	know about the Commission on Voluntary Health Agencies' recognition program for state health agencies.	832
10.	482	(60%)	have participated in discussion of Public Law 89-749.	810
11.	206	(25%)	know how often the ISMA Board meets.	840
12.	187	(22%)	know the Board chairman by name.	839

QUESTION				NUMBER OF RESPONDENTS
13.	324	(39%)	feel they understand the intent of Public Law 89-749.	825
14.	258	(31%)	have visited ISMA headquarters.	844
15.	340	(42%)	know a member of an ISMA commission.	816
16.	522	(63%)	know their district medical society officers, and	829
17.	632	(76%)	have attended a district medical society meeting.	831
18.	648	(78%)	have heard of IMPAC, and	828
19.	445	(72%)	believe in the objectives of IMPAC.	616
20.	308	(37%)	know of the ISMA Junior-Senior Day Program, and	831
21.	576	(69%)	are aware of the ISMA physician placement service.	835
22.	705	(86%)	read the *ISMA News Flash.*	821
23.	179	(22%)	know how ISMA commissions are structured.	821
24.	356	(43%)	know the president of ISMA, and	834
25.	332	(40%)	have heard of the ISMA's new member orientation program.	834
26.	(ISMA major function — free response)			
27.	(better service recommendations — free response)			
28.	(see chart)			812
29.	506	(61%)	regularly attend county society meetings.	
	186	(22%)	attend most of the time.	
	138	(17%)	hardly ever attend.	830
30.	476	(76%)	consider society meetings important.	630
31.	213	(26%)	have served on an ISMA committee or commission, or	830
32.	449	(62%)	would be willing to serve.	727
			type of practice:	
33.	481	(58%)	solo	
	163	(20%)	partnership	
	92	(11%)	group	
	38	(5%)	clinic	
	29	(4%)	hospital	
	10	(1%)	industry	
	13	(2%)	other	826

34. The following priorities were assigned to (proposed) activities of the ISMA by the number of members indicated. NOTE: Percentages for part A are based on the number of respondents who indicated a priority for part A.

	Indicated Priority	1	2	3	4	5	6	7	8	9
A.	Scientific Meetings (574) *	303 53%†	80 14%	71 12%	41 9%	22 4%	21 4%	13 2%	12 2%	11 2%
B.	Political Lobbying (497)	165 33%	130 26%	80 16%	45 9%	26 5%	15 3%	12 2%	10 2%	12 2%
C.	Legislative Reporting (480)	60 12%	124 26%	93 19%	59 12%	37 8%	44 9%	24 5%	20 4%	19 4%
D.	ISMA Journal (425)	34 8%	81 19%	77 18%	63 15%	43 10%	32 8%	41 10%	27 6%	27 6%
E.	Annual Convention (396)	28 7%	56 14%	58 15%	51 13%	48 12%	45 11%	28 7%	46 12%	36 9%
F.	Education of the Public (591)	149 25%	139 24%	108 18%	81 14%	45 8%	29 5%	18 3%	10 2%	12 2%
G.	Radio, TV Programs (360)	27 8%	46 13%	51 14%	47 13%	47 13%	47 13%	44 12%	27 8%	24 7%
H.	Newsletters (393)	33 8%	36 9%	50 13%	38 10%	60 15%	50 13%	55 14%	45 12%	26 7%
I.	Physician Placement (346)	27 8%	31 9%	52 15%	43 12%	45 13%	38 11%	31 9%	34 10%	45 13%
J.	District Conferences (274)	12 4%	33 12%	35 13%	26 10%	27 10%	20 7%	36 13%	41 15%	44 16%
K.	Socio Economic Legislative Seminars (321)	33 10%	52 16%	50 16%	35 11%	38 12%	30 9%	30 9%	29 9%	24 8%
L.	Field Service (243)	25 10%	37 15%	31 13%	21 9%	23 10%	20 8%	29 12%	27 11%	30 12%

Similarly for the other parts. Many respondents assigned priority 1 to more than one part. Similarly for priorities 2, 3, ...

* number responding

† percentage of those indicating this item on their priority list

ABORTION

QUESTION				NUMBER OF RESPONDENTS
1.	767	(93%)	feel that there should be a law regulating abortion.	827
2.	647	(85%)	feel that the medical association should promote revision of the current law.	765
3.			the following were considered indications for legalized abortion. By	
	728	(93%)	physical hazard to mother	781
	523	(78%)	mental hazard to mother	675
	318	(54%)	emotional hazard to mother	589
	665	(88%)	rape	751
	631	(87%)	incest	665
4.	567	(76%)	feel that there should be an Indiana residence requirement.	745

AVAILABILITY OF HEALTH CARE

1.	698	(84%)	believe quality health care is now readily accessible to the ordinary American.	827
2.	584	(72%)	approve a seven-day work week for all clinical hospital services.	815
3.	196	(24%)	object to allowing foreign medical graduates, who can qualify for licensure, to remain in the United States to practice.	818

QUESTION				NUMBER OF RESPONDENTS
4.	318	(40%)	feel hospitals, rather than the medical profession, should be responsible for providing doctors in emergency rooms.	787
5.	465	(57%)	believe the decreasing supply of general practitioners is primarily the result of medical schools.	815
6.	759	(92%)	forsee a further decrease in the relative proportion for general practitioners, and	826
7.	278	(50%)	can suggest means to counteract this.	551
8.	673	(83%)	approve greater use of para-medical personnel, and	811
	589	(90%)	would accept clinical assistants,	658
	479	(84%)	optometrist in ophthalmologist's office,	568
	373	(70%)	multiphasic screening clinics,	537
	370	(72%)	professional pharmacists,	513
	218	(40%)	midwives,	561
	586	(92%)	surgical technicians,	636
	532	(90%)	orthopedic technicians, and	592
	540	(90%)	clinical psychologists	604
9.	447	(64%)	feels group practice gives the patient more productive service, and	701
	240	(35%)	feels group practice gives the patient more economical service.	684

COST

1.	591	(78%)	feel that organized medicine should make a serious study of fees and related values.	758
	538	(89%)	feel that recommendations should be made for revising current fees based on this study, and	602
	550	(93%)	feel that this study should be on a continuing basis.	594

OTHER

1.	509	(70%)	feel that ISMA should study methods for establishing special association sponsored plans for group insurance programs.	723

ISMA MEMBER SURVEY

Question 28.

Years of Membership	Number of Respondents	Percentage of Total
Less than 1 year	9	1
1 year—5 years	123	15
6 years—10 years	148	18
11 years—15 years	126	15
16 years—20 years	133	17
21 years—30 years	156	19
31 years—40 years	94	12
41 years—60 years	23	3
TOTAL	812	100%

GEOGRAPHICAL DISTRIBUTION OF RESPONDENTS

01	Adams	4	0.5%	48	Madison	9	1.2%
02	Allen	20	2.7%	49	Marion	4	0.5%
03	Bartholomew	11	1.5%	50	Marshall	2	0.3%
04	Benton	0	0.0%	51	Martin	0	0.0%
05	Blackford	2	0.3%	52	Miami	0	0.0%
06	Boone	6	0.8%	53	Monroe	2	0.3%
07	Brown	0	0.0%	54	Montgomery	0	0.0%
08	Carroll	2	0.3%	55	Morgan	6	0.8%
09	Cass	6	0.8%	56	Newton	1	0.1%
10	Clark	2	0.3%	57	Noble	1	0.1%
11	Clay	7	1.0%	58	Ohio	0	0.0%
12	Clinton	2	0.3%	59	Orange	2	0.3%
13	Crawford	0	0.0%	60	Owen	16	2.2%
14	Daviess	8	1.1%	61	Parke	1	0.1%
15	Dearborn	10	1.4%	62	Perry	0	0.0%
16	Decatur	4	0.5%	63	Pike	2	0.3%
17	DeKalb	2	0.3%	64	Porter	9	1.2%
18	Delaware	33	4.5%	65	Posey	3	0.4%
19	Dubois	10	1.4%	66	Pulaski	0	0.0%
20	Elkhart	33	4.5%	67	Putnam	7	1.0%
21	Fayette	1	0.1%	68	Randolph	1	0.1%
22	Floyd	13	1.8%	69	Ripley	2	0.3%
23	Fountain	1	0.1%	70	Rush	1	0.1%
24	Franklin	0	0.0%	71	St. Joseph	65	8.9%
25	Fulton	3	0.4%	72	Scott	1	0.1%
26	Gibson	4	0.5%	73	Shelby	8	1.1%
27	Grant	16	2.2%	74	Spencer	1	0.1%
28	Greene	0	0.0%	75	Starke	1	0.1%
29	Hamilton	0	0.0%	76	Steuben	2	0.3%
30	Hancock	5	0.7%	77	Sullivan	1	0.1%
31	Harrison	0	0.0%	78	Switzerland	0	0.0%
32	Hendricks	7	1.0%	79	Tippecanoe	28	3.8%
33	Henry	12	1.6%	80	Tipton	5	0.7%
34	Howard	10	1.4%	81	Union	1	0.1%
35	Huntington	5	0.7%	82	Vanderburgh	53	7.3%
36	Jackson	0	0.0%	83	Vermillion	3	0.4%
37	Jasper	3	0.4%	84	Vigo	7	1.0%
38	Jay	7	1.0%	85	Wabash	5	0.7%
39	Jefferson	11	1.5%	86	Warren	0	0.0%
40	Jennings	0	0.0%	87	Warrick	2	0.3%
41	Johnson	10	1.4%	88	Washington	0	0.0%
42	Knox	0	0.0%	89	Wayne	34	4.7%
43	Kosciusko	9	1.2%	90	Wells	15	2.1%
44	LaGrange	3	0.4%	91	White	4	0.5%
45	Lake	103	14.1%	92	Whitley	4	0.5%
46	LaPorte	27	3.7%	98	Out of state	1	0.1%
47	Lawrence	9	1.2%	731	Respondents		

CHAIRMAN: If there is no other business our next matter is to determine the date of our next meeting. Does anyone have any objection to the 6th or 7th of September? Hearing none, this will be our next meeting date. I would like to suggest that the evening of the 6th be devoted to a "think session" and the three items which we have skipped over, that is the two reports of the AMA Board of Trustees and the report of the AMA Future Planning Committee. I would recommend that you go through these and make notes so that you will be qualified to discuss these reports at our September 6th meeting.

COMMERCIAL ANNOUNCEMENTS

PSYCHIATRISTS—GENERAL PRACTITIONERS: Immediate apenings. 950-bed madern NP hospital. Starting salary $20,000 plus—dependent upan qualificatians, supplemented by attractive benefits: retirement, life and health insurance, liberal leave system. Living quarters pravided at nominal charge. Equal opportunity employer. Contact Chief af Staff, Veterans Administratian Hospital, Tamah, Wis. 54660.

BUY AND TRY: Wye Plantatian Aberdeen-Angus frazen semen fram Advanced Register P.R.I. sires officially gaining aver faur paunds per day or whose 365-day weights are abave 1,200 pounds. (Performance tested sires always far sale.) WYE PLANTATION, Queenstown, Maryland 21658. Telephanes: 301-827-7166 ar 301-827-7160.

RESIDENCY IN PHYSICAL MEDICINE AND REHABILITATION: University of Cincinnati. Faur faculty physiatrists. Basic science program. Broad training in rehabilitatian, electramagraphy, and acute physical medicine. Write Robert H. Jebsen, M.D., Prafessar and Chairman, Dept. af Physical Medicine & Rehabilitatian, University of Cincinnati, College of Medicine, Eden & Bethesda Aves., Cincinnati, Ohia 45219

INTERNIST, PEDIATRICIAN, ORTHOPEDIST, GENERAL PRACTITIONER: ta jain nineteen-man Wiscansin graup lacated in callege cammunity af 40,000 with excellent hospital facilities. Far further infarmatian, cantact D. R. Griffith, M.D., Midelfort Clinic, Eau Claire, Wiscansin.

IMMEDIATE OPENING: Internist ar general practitianer ta jain six man multi-specialty group in northeastern Wiscansin. Excellent prafessianal appartunity to practice in a friendly cammunity, anly twa actively practicing physicians (general practitianers) in the cammunity autside of our clinic. Salary commensurate with training and experience first year and then full partnership. Ideal, safe small city living far the family an scenic Lake Michigan with excellent fishing, boating and hunting. All this and still anly 1½ haurs drive ta Milwaukee ar 45 minutes to Green Bay ar lavely Door Caunty. Far camplete details cantact Rabert E. Myers, M.D., Garfield at 23rd, Twa Rivers, Wiscansin 54241.

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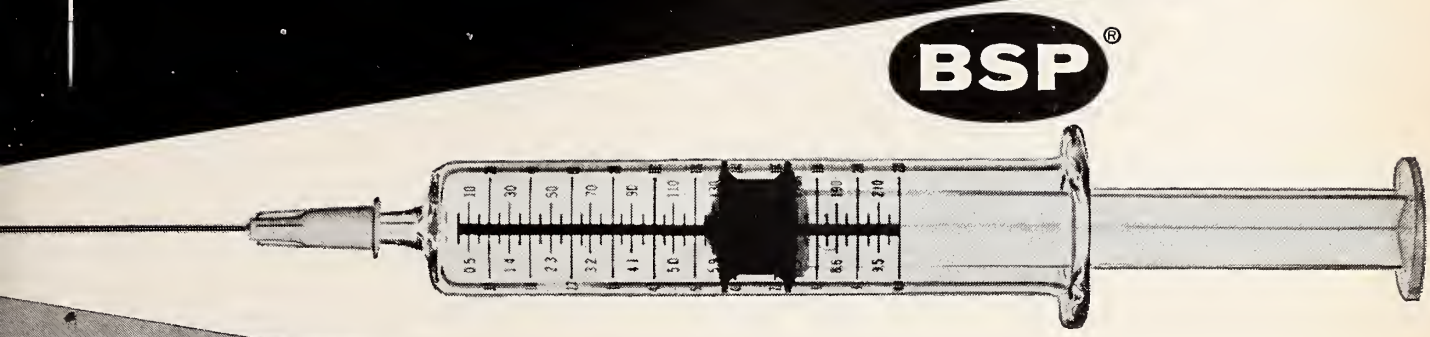
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Contents

SCIENTIFIC

Fistula Between Bowel and Urinary Tract, Myron H. Nourse, M.D., Indianapolis 1207

Obturator Obstruction of the Intestine: Report of Two Unusual Cases, Ralph O. Butz, M.D., Mike Rench, M.D., Muncie 1213

Hypsarrhythmia Accompanying Tetany of the Newborn, Jack M. Troy, M.D., Hammond 1216

X-Ray Conference: Arteriographic Diagnosis of Acute Pancreatitis, Erich K. Lang, M.D., Shreveport, La. 1218

Fractures and Orthopedic Problems: The Development and Treatment of Deformity in Pseudoachondroplastic Dwarfs, Richard E. Lindseth, M.D., Indianapolis 1220

Electrocardiogram of the Month: Pacemaker Electrocardiography (III), Charles Fisch, M.D., Indianapolis 1229

EDITORIALS

Diabetes Detection Week 1237

Son of Three-Legged Stool 1237

The Laboratory Question (Guest) 1238

AMA Clinical Convention (Guest) 1238

Editorial Notes 1239

SPECIAL FEATURES

I.U. School of Medicine Postgraduate Courses 1209

The Katherine Hamilton Mental Health Center, A. W. Cavins, M.D., Terre Haute 1250

Tyrannical Taxation, A. G. Blazey, M.D., Washington, Ind. 1252

REGULAR FEATURES

What's New? 1195

President's Page 1197

Month in Washington 1200

Fourth Estate 1205

From The Journal 50 Years Ago 1224

The Woman's Auxiliary Reports to ISMA 1242

Gleaned from the British Medical Journal, Jack W. Hickman, M.D., Indianapolis 1244

What About Medical Care Cost? (One of a Series) 1254

Medicine at Law 1256

Abstracts, Book Reviews 1260

Annual Meeting Dates of Professional Medical and Allied Organizations 1263

Board of Health Report 1264

News Notes 1267

Future Meetings, Seminars, Courses 1271

Deaths 1272

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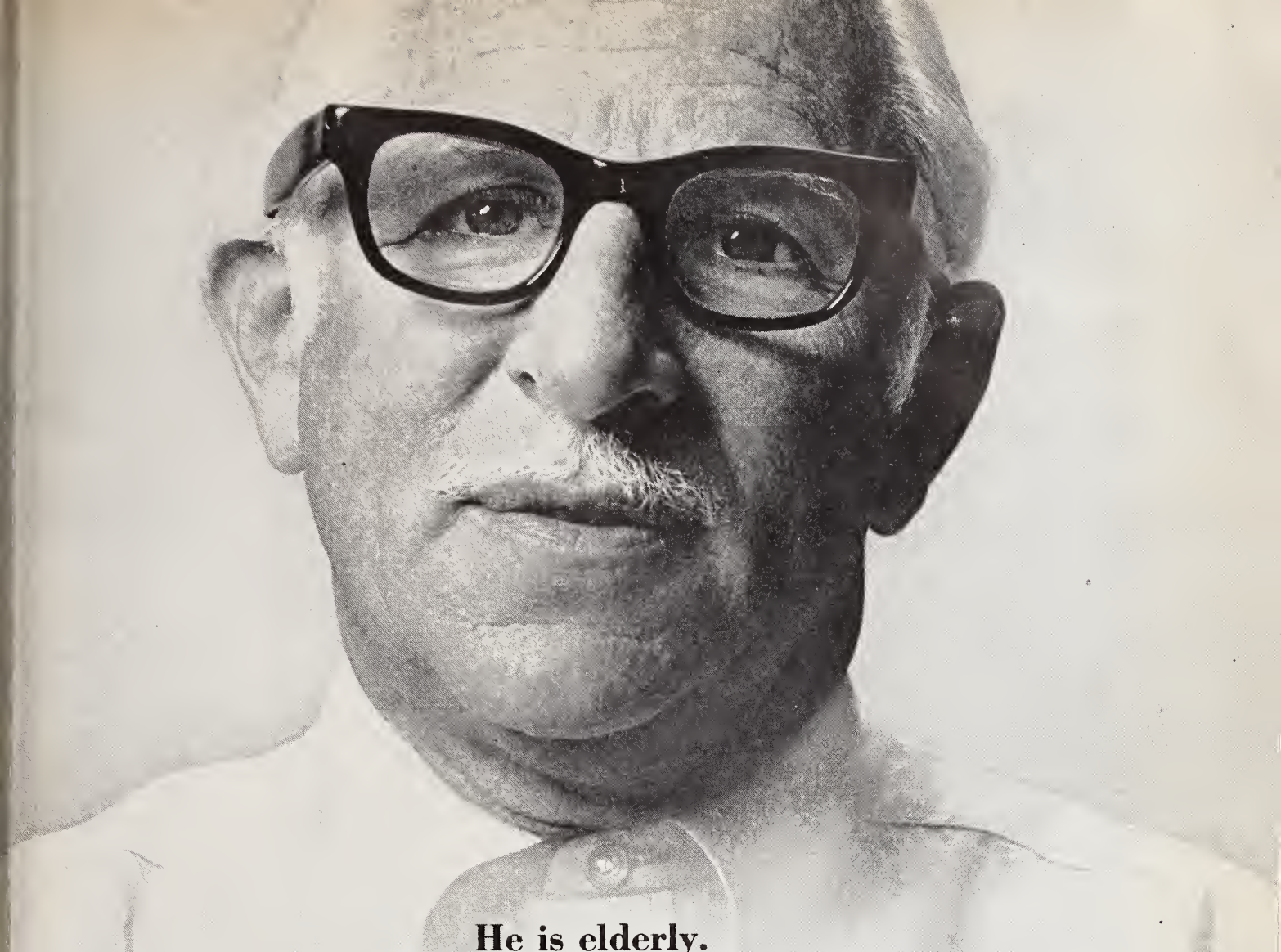
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ma to severe skin manifestations. In a smaller proportion, photo-
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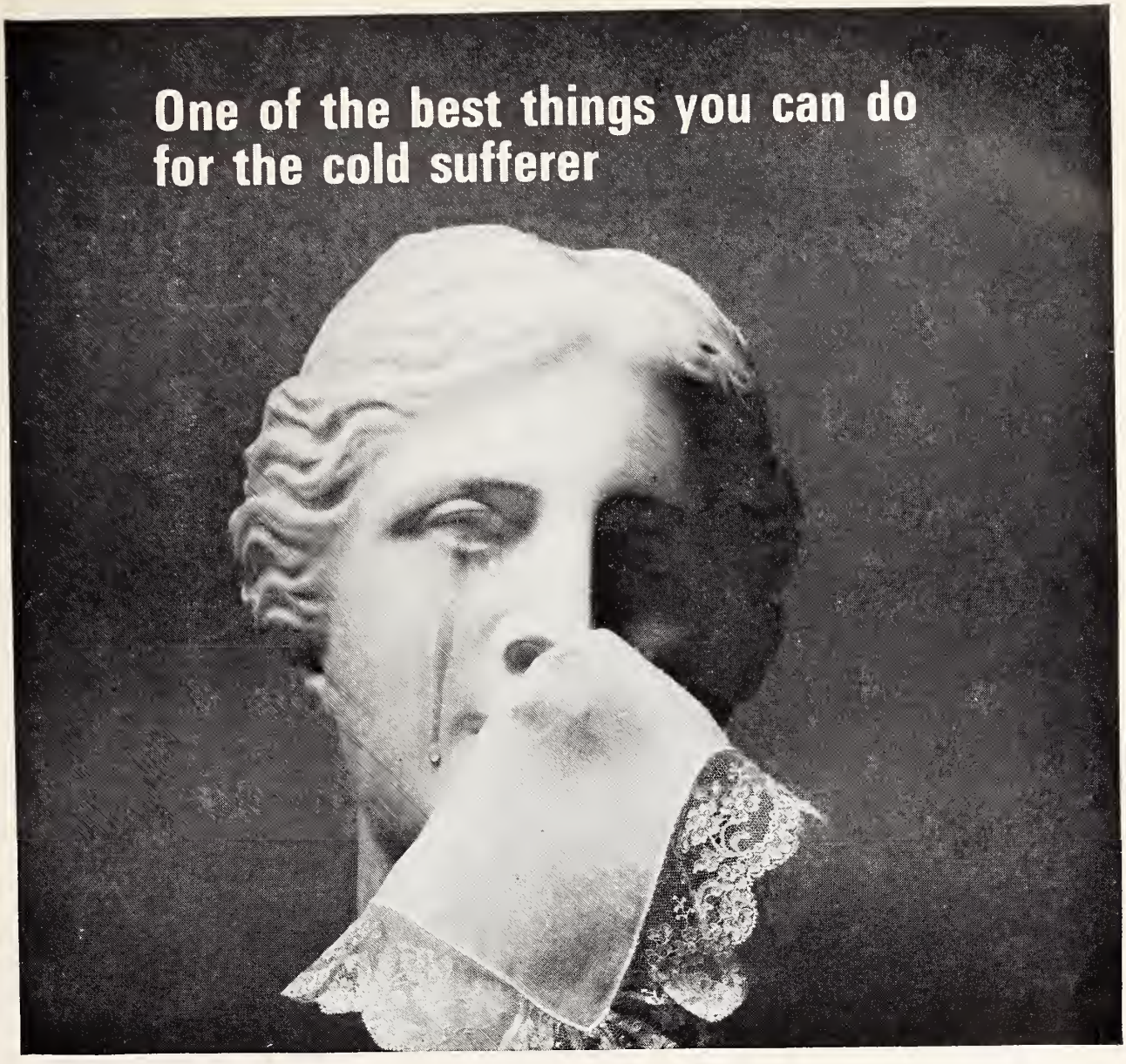
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Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

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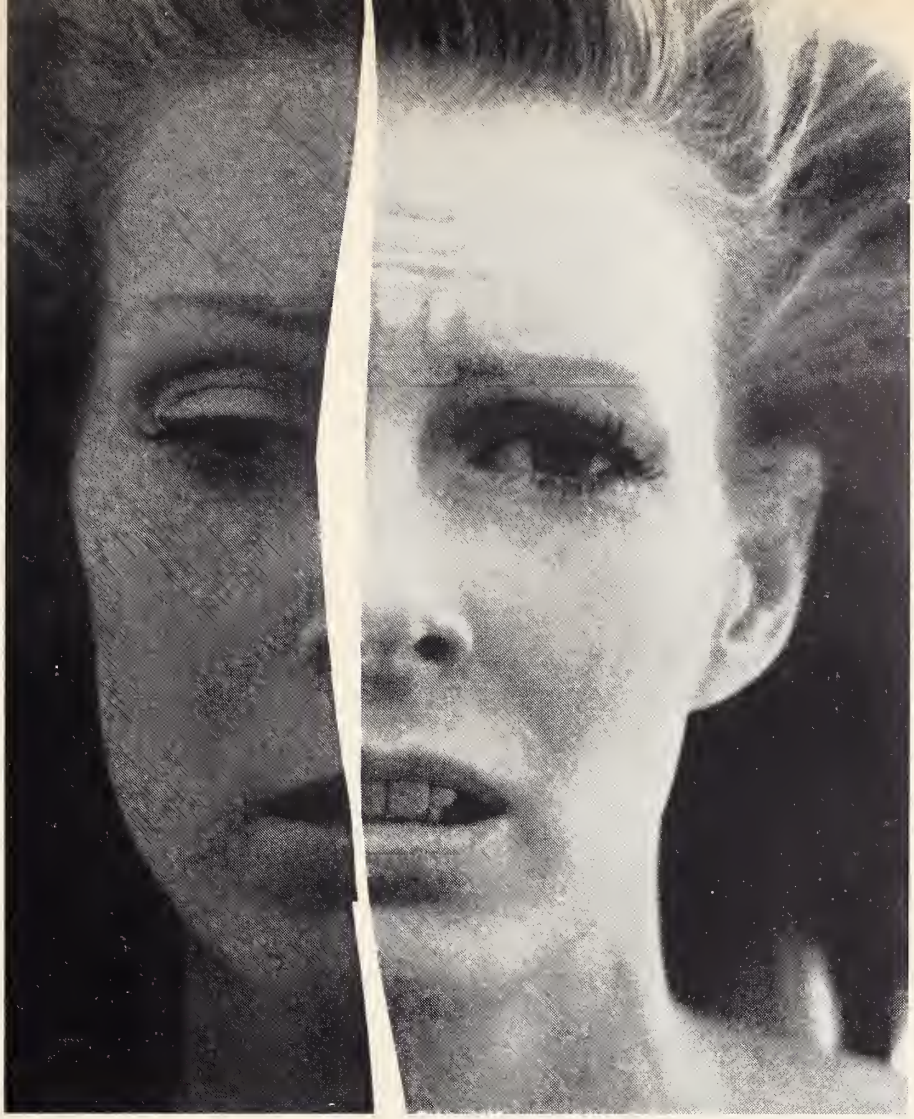
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Mellaril®
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effective in mixed anxiety-depression and in moderate to severe anxiety

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

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Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic/antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

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INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other C depressants. As with all CNS-acting drugs, tion patients against hazardous occupations quiring complete mental alertness (*e.g.*, opera machinery, driving). Though physical and chological dependence have rarely been repo on recommended doses, use caution in ministering Librium (chlordiazepoxide hy chloride) to known addiction-prone individ or those who might increase dosage; withdra symptoms (including convulsions), follov discontinuation of the drug and similar to tl seen with barbiturates, have been reported. of any drug in pregnancy, lactation, or in wo of childbearing age requires that its potet benefits be weighed against its possible haza As with all anticholinergic drugs, an inhibi effect on lactation may occur.

PRECAUTIONS: In elderly and debilita limit dosage to smallest effective amount to clude development of ataxia, oversedation confusion (not more than two capsules per initially; increase gradually as needed and to

or here.



ed). Though generally not recommended, if mbination therapy with other psychotropics ems indicated, carefully consider individual armacologic effects, particularly in use of po- ntiating drugs such as MAO inhibitors and enothiazines. Observe usual precautions in esence of impaired renal or hepatic function. radoxical reactions (*e.g.*, excitement, stimula- on and acute rage) have been reported in psy- iatric patients. Employ usual precautions in atment of anxiety states with evidence of im- nding depression; suicidal tendencies may be esent and protective measures necessary. Vari- le effects on blood coagulation have been orted very rarely in patients receiving the ug and oral anticoagulants; causal relation- ip has not been established clinically.

ADVERSE REACTIONS: No side effects or nifestations not seen with either compound ne have been reported with Librax. When lordiazepoxide hydrochloride is used alone, owsiness, ataxia and confusion may occur, ecially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

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for unearthly cough

Benylin®
EXPECTORANT



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An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind.

BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

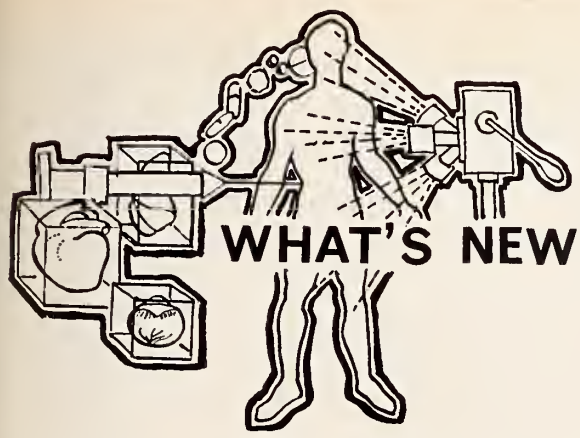
ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

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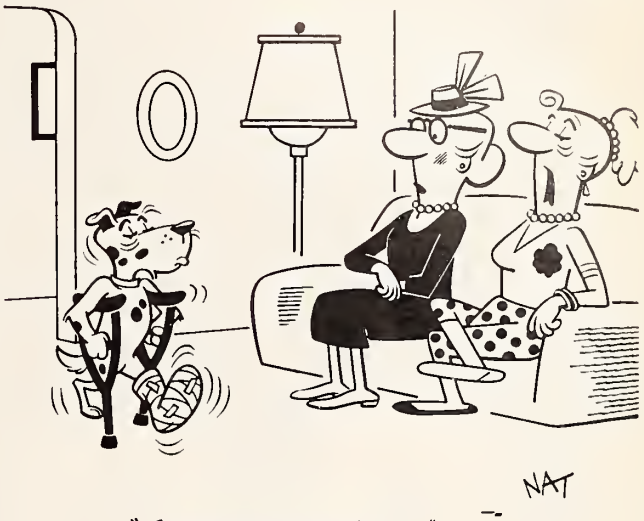
"Familiar Medical Quotations," edited by Dr. Maurice B. Strauss and published by Little, Brown and Company, appeared recently. Compiled by an editorial board which includes S. O. Waife of Eli Lilly Research Laboratories, the book is in the tradition of Bartlett's "Familiar Quotations." More than 7,000 quotations are listed under an extensive list of subject categories.

* * *

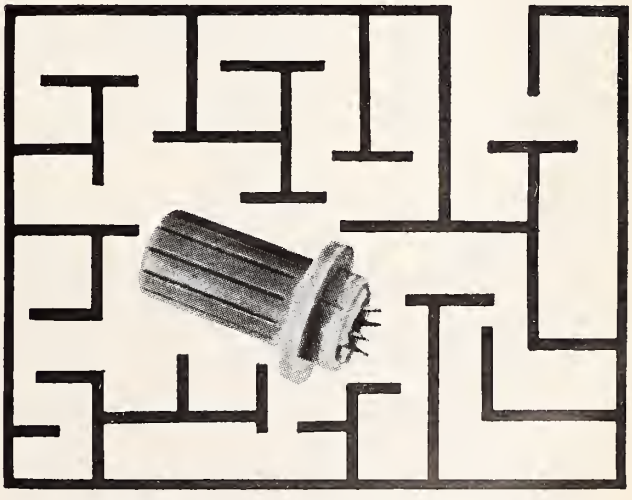
H. W. Anderson Products is marketing a new portable gaseous sterilization system for use with objects which are sensitive to heat or water. It utilizes ethylene oxide which is maintained in liquid form under pressure in glass ampules. An ingenious arrangement of two permeable plastic bags allows the release of the liquid ethylene oxide and its conversion to a gaseous state by breaking the ampule which is contained within the inner of the two bags. Objects to be sterilized are placed between the inner and outer bags. Diffusion of the gas takes place through the inner bag, which builds up a concentration of up to 50% within the outer bag, accomplishes the sterilization and then slowly diffuses through the outer bag into the atmosphere. Stainless steel containers are used to protect the plastic bags and to prevent ignition of the flammable gas by sparks or static. The system is trademarked Anprolene. C. R. Bard is the marketing agent.

* * *

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"THE MAILMAN BIT HIM."



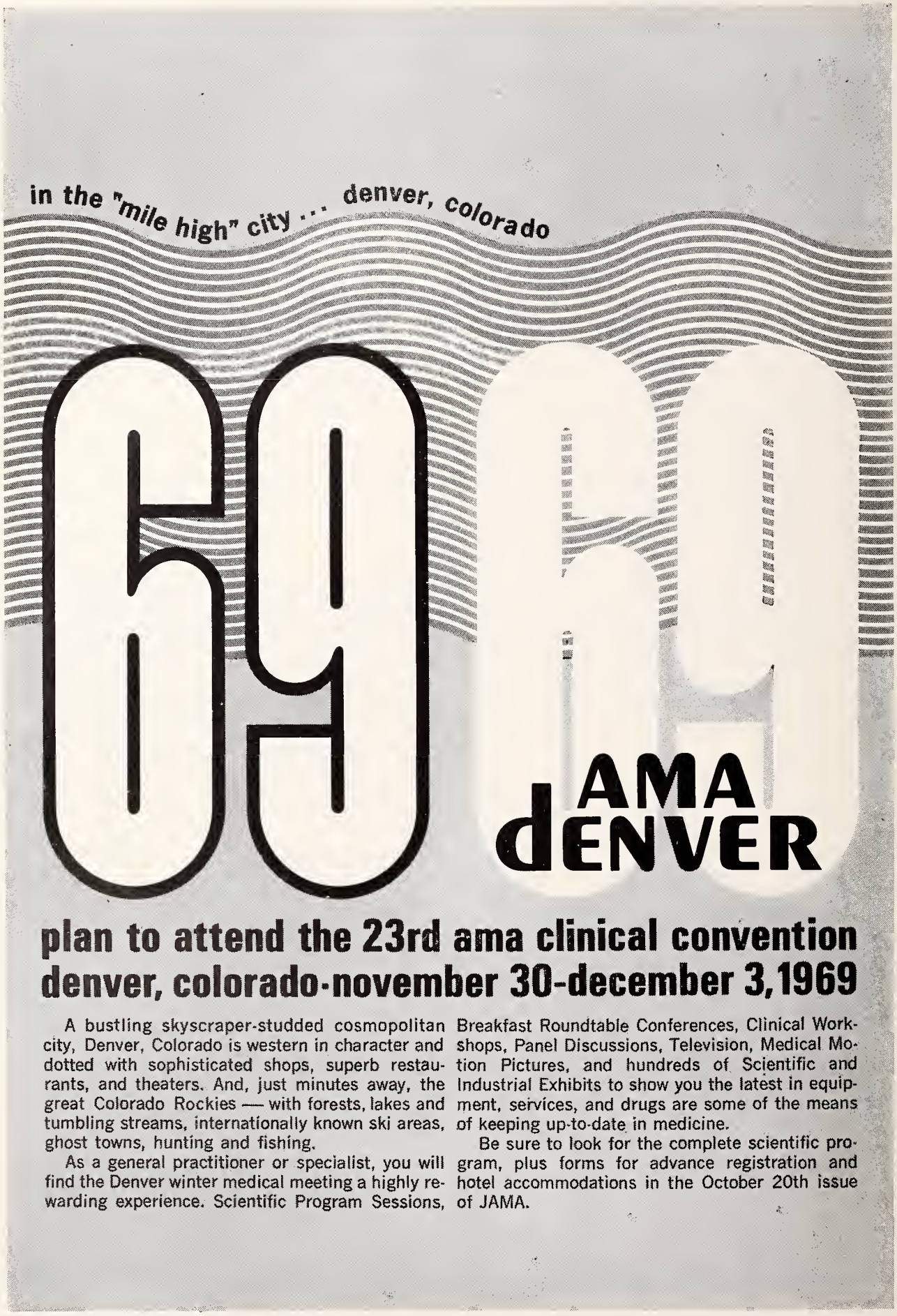
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Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

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plan to attend the 23rd ama clinical convention denver, colorado-november 30-december 3, 1969

A bustling skyscraper-studded cosmopolitan city, Denver, Colorado is western in character and dotted with sophisticated shops, superb restaurants, and theaters. And, just minutes away, the great Colorado Rockies — with forests, lakes and tumbling streams, internationally known ski areas, ghost towns, hunting and fishing.

As a general practitioner or specialist, you will find the Denver winter medical meeting a highly rewarding experience. Scientific Program Sessions, Breakfast Roundtable Conferences, Clinical Workshops, Panel Discussions, Television, Medical Motion Pictures, and hundreds of Scientific and Industrial Exhibits to show you the latest in equipment, services, and drugs are some of the means of keeping up-to-date in medicine.

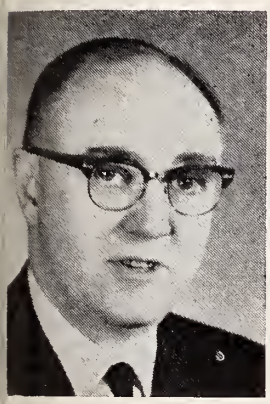
Be sure to look for the complete scientific program, plus forms for advance registration and hotel accommodations in the October 20th issue of JAMA.

President's Page

FACULTY—STUDENT RETREAT

A Retreat-Seminar of I.U. Medical School faculty, students and ISMA members was held at French Lick the week-end of September 20-21.

This was a pilot program. It was planned with only a tentative format and was "played by ear" throughout.



A wide range of subjects was discussed. Of special interest were community health medicine, medical school curricula, admissions procedures, social aspects of health care, and possible changes in the roles of the physician and allied health professionals.

Candor and good-will were notably evident. This permitted discussions leading to awareness of problems and exposure to viewpoints among the groups represented. Any such means of bridging the insulations between teachers, students, and practitioners is to be encouraged. Many of the presumed differences are then found to be more apparent than real.

I came away from this conference deeply impressed by the intelligence and the sincerity of today's medical student. The ones I've met are serious, informed and idealistic.

I was likewise favorably impressed by the faculty who were at the meeting. They have an appreciation of the problems, an open-mindedness to change, if it offers progress, and a dedicated devotion to their task of training tomorrow's doctors.

We should develop further ventures in this area. Our Commission on Medical Education is most likely the proper vehicle; five of its members participated in the French Lick meeting. They can assess the potential benefits and the most suitable techniques for further consideration.

Based on our experience with this first conference, I recommend that the Retreat-Seminar be continued as a regular feature.

WHY NOT BE IN CHARGE?

For the second year, we have carried out an orientation program for members who have recently joined the association.

The benefits, both to the new member and to ISMA, can be considerable.

This new undertaking, mandated by the Bylaws, has required much thought, hard work and careful planning. It is a credit to the trustees' committee and its chairman, Dr. William Clark.

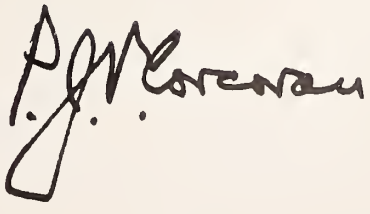
Every physician should seek active participation in the affairs of organized medicine. This new indoctrination course is meant to show him how.

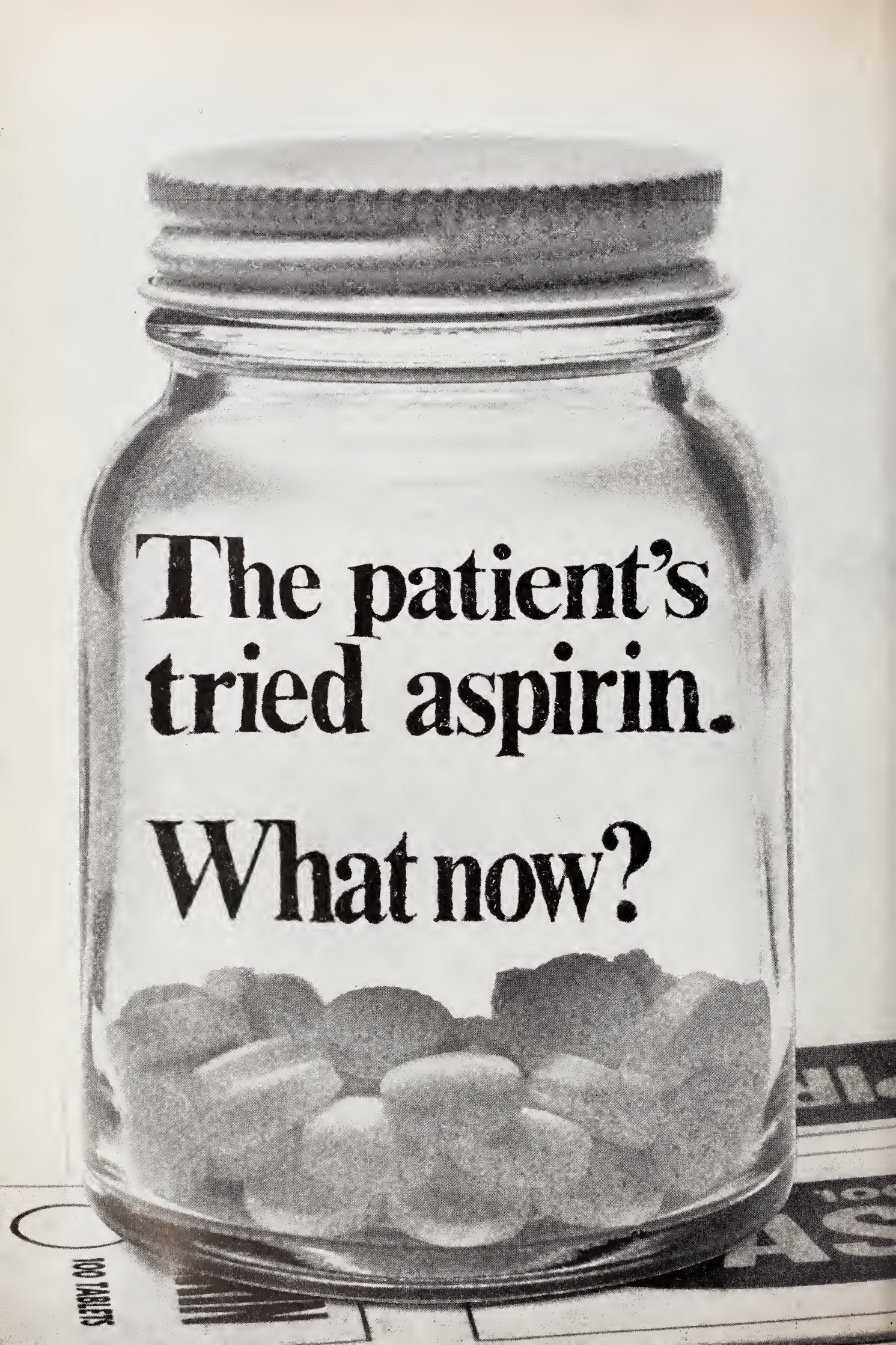
Physicians need a unified group to act for and speak for *all* members of the profession. Our association is the logical one to do it in Indiana. It is better to use the presently existing means than to formulate a new and competitive one.

There should be no reason why ISMA cannot enlist all eligible doctors and be responsive to their needs and representative of their attitudes.

If a doctor is not active in his medical society, there is scant excuse for complaints that the association may not reflect his views. Adequate means are available in my own county society for entry into its functions. A minority group could not stay in control if the majority remain equally participative and informed. If local societies are fully representative, the state association will be likewise.

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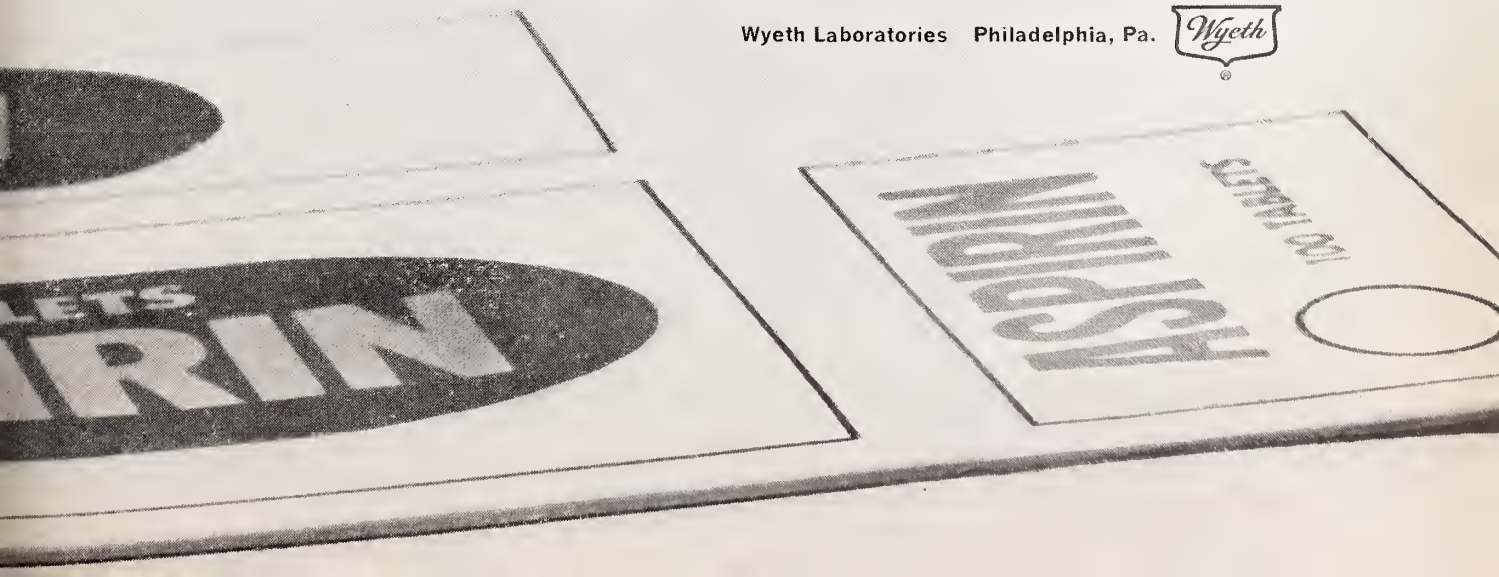
Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

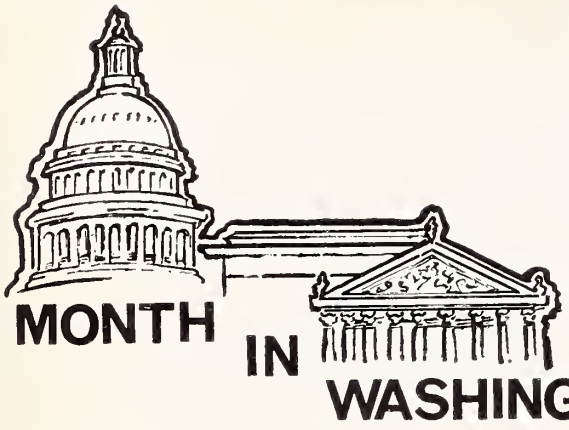
Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

Overdosage: See precautions section for management of overdosage.

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This summary of what is happening in Washington i prepared by AMA's Capitol office and air-mailed t *The Journal* on the ninth of each month precedin month of issue.

WASHINGTON, D.C.—A Food and Drug Administration advisory committee found oral contraceptives to be "safe," but reported that British and U.S. studies had established "an etiologic relation between thromboembolic disorders" and their use.

THE ADVISORY Committee on Obstetrics and Gynecology, making its second report on oral contraceptives, said that their benefits outweighed the risks sufficiently to designate them "safe" within the intent of the federal law.

AS FOR THE potential carcinogenicity of oral contraceptives, the report said no conclusion could be drawn at this time.

THE COMMITTEE called for intensive research along three lines: 1) possible relationship of hormonal contraceptives and carcinoma of the breast and uterus; 2) determination of the basis and prognosis of metabolic alterations produced by hormonal contraceptives; and 3) development of new methods of contraception.

THE COMMITTEE, in its initial report three years ago, approved of oral contraceptives with reservations. It now said that these reservations appear to have been justified because of the adverse reactions reported in both scientific literature and the general press. But the report concluded:

"WHEN THESE potential hazards and the value of the drugs are balanced, the committee finds the ratio of benefit to risk sufficiently high to justify the designation safe within the intent of the legislation" (Kefauver-Harris Amendments of 1962).

THE REPORT SAID scientific studies "suggest that the mortality from thromboembolic disorders attributable to the oral contraceptives is about three per 100,000 women per year, adding less than three percent to the total age-specific mortality in users of these drugs." In a U.S. study, the risk of thromboembolism to a woman using hormonal contraceptives was estimated by indirect methods to be 4.4 times that of a non-user.

THE REPORT said there is no evidence that any metabolic alterations induced by the oral contraceptives pose serious health hazards.

THE EFFECTIVENESS of oral contraceptives was found to be significantly higher than for intrauterine devices or traditional methods.

IRS RULES FOR PHYSICIAN CORPORATIONS

ABANDONING a long court fight, the Internal Revenue Service reversed

itself and ruled that organizations of physicians authorized under state professional association laws will be treated as corporations for tax purposes.

THE IRS announced that it would not appeal to the Supreme Court two recent decisions by U.S. courts of appeal favoring the professional association. In accordance with these court decisions, the IRS said, "organizations of doctors, lawyers and other professional people organized under state professional association acts will, generally, be treated as corporations for tax purposes."

FORTY-TWO states have such laws which offer tax benefits, including deferment of the tax on pension plan contributions until retirement.

THE COURT controversy over IRS treatment of the professional associations for tax purposes dated back to the early 1950's. It was given a "Kintner" label in 1954 when an appeals court ruled in favor of the professionals in a case brought by Arthur Kintner, M.D., Missoula, Mont.

NEW PHYSICIAN AUGMENTATION PROGRAM

THE FEDERAL GOVERNMENT has started a program designed to increase enrollment in the nation's schools of medicine and osteopath by 4,000 over the next four years.

KNOWN AS THE Physician Augmentation Program, the activity, under the Department of Health, Education and Welfare, supports the addition of 1,000 first year places commencing with the fall term of 1970. These places are in addition to any increase to which the schools have already committed themselves. Total enrollment through this program is expected to be about 4,000 in the fourth year of operation. The Physician Augmentation Program is authorized under the Health Manpower Act of 1968.

GRANTS WILL BE awarded on a national competitive basis to those schools of medicine and osteopath that document their intention to institute a major increase in their first-year enrollment and that appear to have the greatest potential for achieving major increases with their own resources as supplemented by funds allocated by the program.

ATTEMPT TO CONTROL MEDICAID COSTS

ROBERT H. FINCH, secretary of Health, Education and Welfare, proposed that state medicaid administrators work more closely with state medical societies on cost control in the federal-state health care program.

HE ALSO SAID that the states should review more claims in efforts to control medicaid costs.

FINCH GAVE his views on controlling medicaid costs in a letter to Sen. Abraham Ribicoff (D., Conn.) who had asked what was being done and what additionally could be done about rising expenditures in the program.

IN ANSWER to a question as to what states "could be doing under exist-

Continued

ing law to control medicaid costs more efficiently," Finch said:

"ONE ANSWER is to spend more money on the claims review function. For example, there are two states where annual medicaid expenditures are in excess of one hundred million dollars. One employs seven people for its review function, the other employs 70. The latter state has very effective control over costs and utilization.

"BUT I AM COMING to believe that a major factor is the degree to which physicians are involved in the program, not simply as purveyors of medical care but also as watchdogs of costs and guardians of quality. They generate the bulk of medicaid expenditures. They authorize admissions to hospitals and skilled nursing homes and they write prescriptions. The need for genuine physician participation in controlling costs is self-evident. A state medicaid administrator would be well advised to make extensive use of his medical advisory committee and to engineer the plan in detail through the state medical society."

AS TO WHAT states already are doing, Finch said:

"SOME STATES are using prior authorization of services (emergencies excepted). Some use fee schedules. Some use audit tolerance levels. Some incorporate parameters of medical care into their data processing systems. Some develop client and purveyor profiles. Some use computers to process claims. Others contract the review function to a fiscal agent, e.g., a Blue Cross plan. Some use a medical audit and some have been doing very little."

RIBICOFF SAID in his letter to Finch that he understood "there is very uneven performance of medicaid program review throughout the nation."

PEER REVIEW under leadership of state and county medical societies has top priority in the American Medical Association recommendations for controlling costs in both medicaid and medicare. A report of the AMA board of trustees approved by the house of delegates at the 1969 annual convention in New York strongly urged that:

—"PEER REVIEW be assigned the highest priority by the state and county medical societies; that where existing mechanisms exist, they be strengthened, and where they do not, they be promptly established.

—"QUICK AND decisive action be taken, in appropriate fashion, to discipline those few physicians determined after investigation to be abusing medicare and medicaid, either fraudulently or otherwise."

THE AMA RECOMMENDATIONS for cost control in government health programs also include:

—"THE PROMOTION of innovative health service delivery systems for low income communities with emphasis on ambulatory care.

—"PROGRAMS BY local medical societies to insure preservation of quality health care in the face of cost containment measures." ◄



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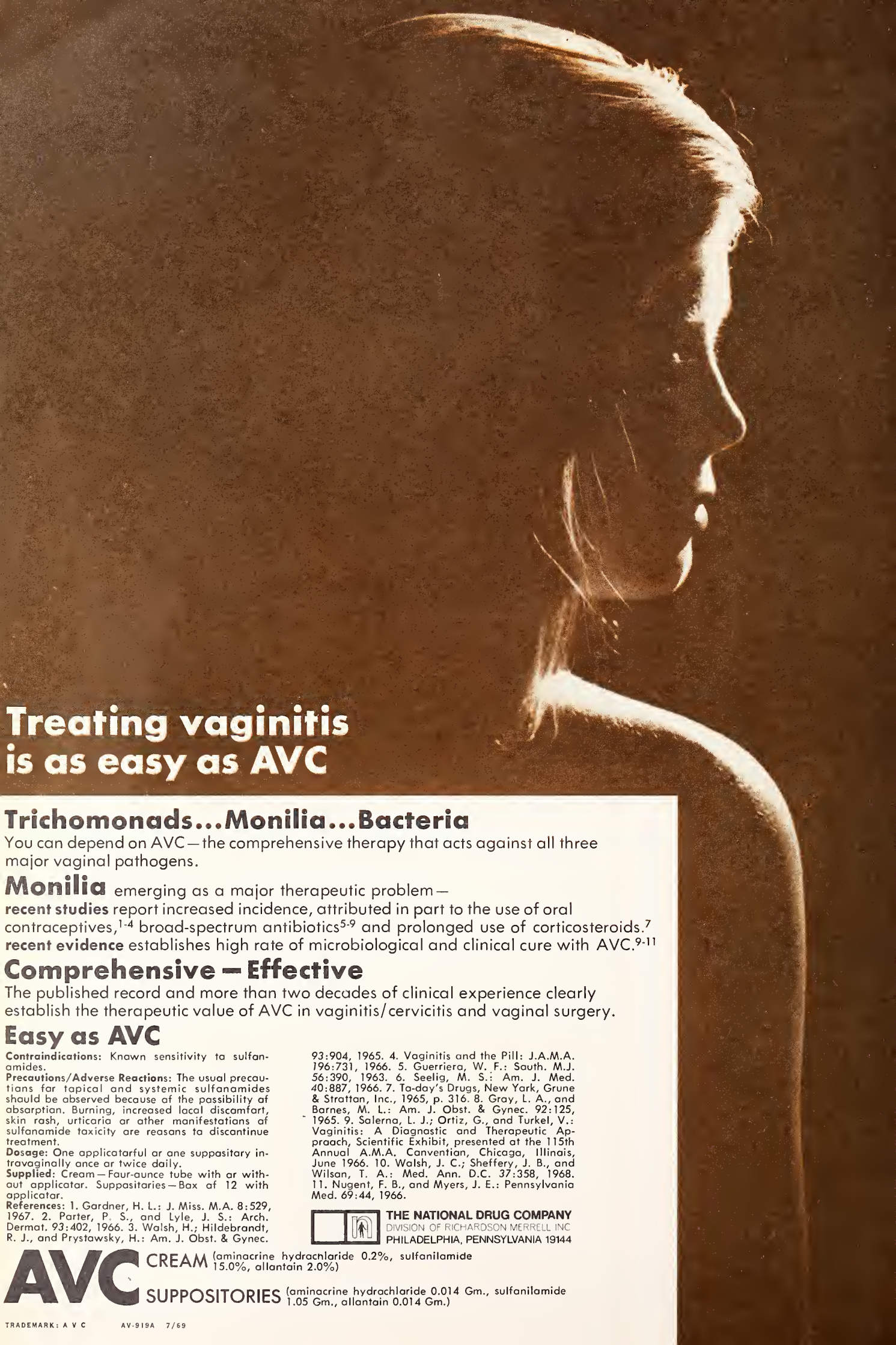
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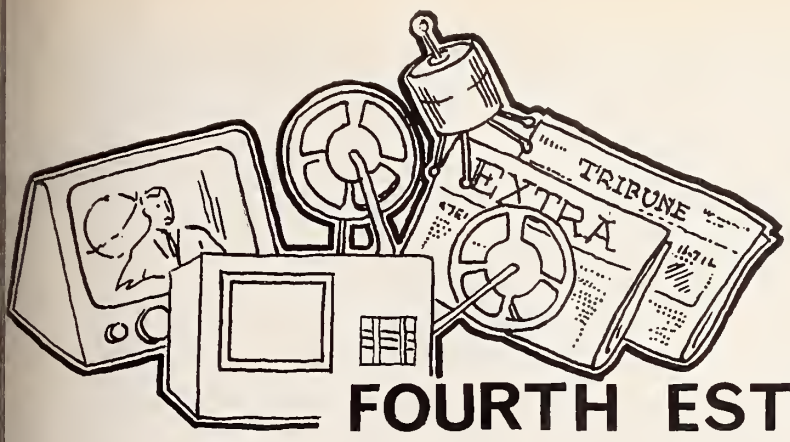
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FOURTH ESTATE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

The "Compleat" Physician

The general practitioner is the backbone of American medicine. But he has been overlooked in recent years in the trend to specialization. Now, he is a specialist also. He will be the "compleat" physician, as the president of the American Academy of General Practice, Dr. Maynard Shapiro, explained.

The medical profession has finally endowed the general practitioner with a lofty new status. It has made Family Medicine a specialty. It is now the 20th of the medical specialties, joining such highly held areas as surgery, pediatrics, gynecology, internal medicine, pathology, psychiatry and thirteen others.

The specialties have been competing to attract medical students to their ranks. Formerly, a young doctor could enter general practice in most states after completing one year of internship. The new requirement for a specialist in family medicine will be for three years of residency training followed by a written examination for certification. His general studies will emphasize the humanities and psychology, as well as the conventional medical subjects.

The general practitioner, now the family physician, knows each patient, how he lives, what his problems are. He can allay a patient's fear in a few minutes' conversation. He deserves to be called a specialist.—*Logansport Pharos-Tribune & Press*, June 12, 1969.

Take Two Aspirin . . .

Having done in a second Indiana medical school last March by vetoing the General Assembly's "blue ribbon" bill, Gov. Edgar D. Whitcomb pronounced the corpse lifeless the other day even as he named a commission on medical education.

"This commission," he lectured its members, "may consider that the School of Medicine of Indiana University at Indianapolis should continue as the primary center for education in the health care professions for the immediate future."

He conceded that other universities in the state could offer "basic medical sciences," but ruled out any full-fledged medical schools other than the one in Indianapolis.

Thus ends hope that even the 1971 or 1972 legislatures will be able to launch the state toward the critically-needed goal of a second state medical center. Unless the governor has an uncharacteristic change of heart, those assemblies will fare no better than the 1969 and 1967 school study bills vetoed.

The governor is not likely to have a change of heart, judging from his instructions to the commission.

The only hope, indeed, lies with legislative over-riding of a past or future veto. If the assembly shifts to annual sessions in 1971, it would be in a somewhat better position to impose its will on the medical school issue, because it will, for the first time, be an ongoing body with continuity of membership.

But to be realistic, there are more "ifs" than certitudes in the short-range prospect of a second Indiana medical school.

Like so many other needs in Whitcomb-governed Indiana, the medical school may have to await a more progressive and realistic chief executive.

Meanwhile, if the doctor shortage begins to pinch, take two aspirin and call the governor's commission on medical education in the morning.—*South Bend Tribune*, June 19, 1969.

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION
Supervised by THE COUNCIL
Volume 62 — October 1969 — Number 10

Urinary-intestinal fistulization varies in incidence but is most common in the lower urinary tract. The result of treatment depends on the primary cause: good with inflammation, poor with malignancy.

Fistula Between Bowel and Urinary Tract

MYRON H. NOURSE, M. D.
Indianapolis

SPONTANEOUS internal fistula between bowel and upper urinary tract (kidney and ureter) is truly a surgical curiosity. Nephroesophageal fistula has not been reported. Nephrogastric fistula is extremely rare. Nephrointestinal fistula is more common, but still considered a relatively rare disease with only 112 cases reported in the literature up until 1958.[1] The incidence of the disease appears to have decreased during the last 10 years.

One of the most uncommon types is pyeloduodenal fistula according to McEwan[2] whose review of the world literature revealed only 23 such cases reported. The commonest causes are chronic renal inflammation associated with renal calculus. Involvement with any portion of the small intestine in fistula formation with the kidney is rare.

Nephrocolic fistula is the commonest form of nephrointestinal fistula. It is usually caused by obstruction of the upper urinary tract, infection, perforation of a hydronephrosis and perinephric abscess formation. Fistula formation follows erosion of the abscess through the bowel wall. Prior to chemotherapy in 1936, tuberculosis was the commonest cause of reported cases. Nonspecific inflammation is now a more common cause than tuberculosis. Renal malignancy is an extremely rare cause.

The diagnosis of nephrocolic fistula depends largely upon a long standing history of renal disease, a chronically ill patient and radiologic examination. Retrograde pyelography is the most informative diagnostic study. Treatment will vary with the individual patient. Some form of definitive surgery is usually necessary.

Spontaneous ureterointestinal fistula has been reported in isolated instances but only because of its extreme rarity.

Vesicointestinal fistula comprises at least 98% of all spontaneous fistulas between bowel and urinary tract. The condition occurs once in 2,000 operative admissions involving men, three times more often than women (pelvic anatomy).[3] The commonest cause of fistula between bowel and bladder is large bowel diverticulitis. The incidence of diverticulosis in the general population is estimated to be between 5% and 10%. Five percent of the patients with symptoms caused by diverticula develop a fistula of some kind. The incidence of vesicointestinal fistula complicating diverticulitis is reported between 4% and 22%.[4] Carcinoma arising within a colic diverticulum is rare and a search of the literature disclosed an average of 3%.

Intestinal carcinoma is the second most common cause of vesicointestinal fistula. The responsible neoplasm is nearly always found either in the sigmoid colon or rectum. It is generally agreed that the prognosis is these cases remains poor.

Combined records from the Institute of Urology and the Registrar General[5] show that bladder cancer accounted for about 14% of fistulas due to malignant neoplasms. This incidence was second only to intestinal neoplasms.

Realizing then that diverticulitis and carcinoma coli are today the

most common causes of vesicointestinal fistula, there remains a small variety of rare conditions that are clinically important:

(1) Ovarian neoplasms—1-3% of all cases of vesicointestinal fistula due to malignant tumors.

(2) Regional ileitis has been estimated to account for approximately 3% of all types of intestinovesical fistulas. In children with regional enteritis, however, associated fistulas are found in 10%.

(3) Four to 5% of all vesicointestinal fistulas are caused by an appendix abscess. Vesical calculus was present in 50% of reported cases, the probable cause being due to the passage of foreign bodies into the bladder through the fistula.

Symptoms

Presenting symptoms are those of cystitis. Intermittent pneumaturia or fecaluria occur in about one-half of the patients. It is of interest that despite the predominance of urinary symptoms, the underlying primary disease is extravesical in the majority of cases.

Diagnosis

The most reliable method of establishing the presence of a fistula and its underlying cause is a careful cystoscopic examination and bimanual pelvic examination performed with the patient under general anesthesia. Transurethral biopsy may be indicated. Diagnosis is made this way many times even though the fistulous orifice is seen in less than half the cases.

Contrast radiography of the urinary and intestinal tracts sometimes provides useful information suggesting the presence of a fistula but in most instances it offers little help. The cystogram seems to be the more informative of the contrast studies to show bladder-bowel communication.

Sigmoidoscopy will serve to prove the presence or absence of rectosigmoid disease or deformity although rarely does it reveal a fistulous orifice.

Urinalysis is essential and may often reveal fecal material, bile and food residue. Along this line I am reminded of a remark made a few years ago by Dr. Don Creevy stating that "The first patient of this type I saw made his own diagnosis after eating a piece of raspberry pie."

Urinary symptoms with diverticulitis are present on the average of two years or longer. Urinary symptoms with intestinal carcinoma, however, are present no longer than six months. Rectal bleeding frequently accompanies intestinal carcinoma but rarely with diverticulitis.

Prognosis

Vesicointestinal fistula is a complication of a disease process of bowel, bladder or other pelvic organs. Prognosis, therefore, is largely determined by the nature of the primary disease. Spontaneous closure occurs in less than 2% of cases. Kellogg[6] found that although cases are on record in which the fistula persisted for 25 years, the average life duration after its establishment was three years.

Good prognosis can be expected if the fistula is due to intestinal inflammation and reports show a 4-6% operative mortality in this group. When malignant neoplasm is responsible for the fistula, the opposite is true and the outlook poor in most published series.

Treatment

Fistulas caused by diverticulitis can be corrected surgically and a good prognosis expected. In the past many have felt that the one, two or three stage procedure was almost mandatory, believing that temporary diversion of the fecal stream would make the operation easier. Times have changed and the trend today is a one-stage operation to include excision of fistula, repair of both bowel and bladder defect and bowel reanastomosis.[7] The bowel is prepared with appropriate antimicrobial agents prior to surgery.

Reasons for the choice of this procedure are obvious. Because differential diagnosis is uncertain between diverticulitis and neoplasm, these patients should all be advised that abdominal exploration is indicated. Aggressive surgery is not warranted if the presence of a cancerous fistula is established. Regardless of how these are treated, the prognosis is poor and the patient's outlook is bleak.

Summary

Summarizing then, the following remarks are pertinent to the subject of fistula between bowel and urinary tract:

(1) Spontaneous fistula between bowel and upper urinary tract is rare. Nephrointestinal is the most common site and prior to chemotherapy, tuberculosis was the most common cause.

(2) Vesicointestinal fistula comprises at least 98% of all spontaneous fistulas between bowel and urinary tract. The most common cause is large bowel diverticulitis. Intestinal carcinoma is the second most common cause.

(3) Presenting symptoms are predominantly urinary despite the fact the underlying primary disease is extravesical.

(4) Diagnosis is established through the history and physical examination together with careful cystoscopy and bimanual pelvic examination while the patient is under general anesthesia. Contrast radiography of bowel and urinary tracts can be helpful at times.

(5) Prognosis is good if the fistula is due to diverticulitis and uniformly poor when malignant neoplasm is responsible.

(6) The treatment is abdominal exploration. If the cause of the fistula is due to diverticulitis, primary resection and repair is the procedure of choice in most instances, with bowel preparation prior to surgery. Aggressive surgery is futile if the presence of a cancerous fistula is established.

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Obturator Obstruction of the Intestine:

Report of Two Unusual Cases

RALPH O. BUTZ, M.D.
MIKE RENCH, M.D.
Muncie*

A case report covering only the distinguishing features of the entity under consideration can rob the reader of the incidental but singular facts which temper future decisions. The cases which precipitated this report illustrate how experience with the unusual both helps and hinders judgment when chance too quickly repeats the rare event.

Obturator obstructions are intestinal obstructions due to globular, intraluminal foreign bodies. The usual agent is the gallstone.[1] Other foreign bodies are rare agents of a rare condition. A single report of a free balloon as obturator comes from Climo and Scarpaci.[2] Moore et al.[3] describe their problem with a Cantor tube bag and note that Dr. Cantor had anticipated this hazard. A balloon on an intestinal tube, however, is significantly different from one that is free and helps to delineate the pathogenesis of obturator obstruction.

Case Reports

Case 1: This 24-year-old white man appeared at the emergency room about 8 P.M. in severe distress with abdominal pain. Symptoms started earlier the same day with nausea and vomiting. The youth was thin, white, unkempt and of demeanor suggesting emotional instability as well as pain. He held his abdomen rigid, complaining of pain to palpation over the whole lower abdomen although more on the right. Rebound tenderness was present but less than expected from his distress.

Urinalysis showed: 3 to 5 WBC per hpf; sugar negative; protein negative. Blood count: hemoglobin 17 gm; hematocrit 50%; WBC 16,740; 6 bands; 79 segs; 13 lymphs; 2 monocytes.

The same evening we removed the patient's appendix thru a McBurney incision and ran the small bowel for five feet without finding any pathology. A small amount of cloudy serous peritoneal fluid was found. Histology confirmed our impression that the appendix was normal. Nasogastric suction was continued for five days after surgery because of nausea and depressed bowel sounds. The sixth day brought abdominal distention, vomiting and an obstructive x-ray picture. Figure 1 shows the result of a thin barium meal. Faced with this unsatisfactory course and obviously puzzled doctors, the patient recounted accidently swallowing a fluid-filled condom which he was sucking.

Six days after the first surgery the patient was explored through a left paramedian incision. The condom was lodged in the mid ileum; the small bowel was dilated proximally to the ligament of Treitz (Figure 2). Enterotomy, removal of the foreign body and decompression of the small bowel gave an uneventful recovery.

Case 2: This 19-year-old white man



FIGURE 1
X-RAY of abdomen following ingestion of thin barium (Case 1). Compare the shadow in the left lower quadrant with the foreign body (Figure 3).

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FIGURE 2

PICTURE taken at the operating table (Case 1) showing the dilated bowel proximally, the sharp transition to collapsed bowel distal to the obstruction and the outline of the foreign body in the intestine including the "nipple" on the leading end.



FIGURE 3
THE foreign body removed from Case 1.

came to the emergency room about one hour after the onset of generalized abdominal pain, nausea and vomiting. Symptoms had started shortly after his breakfast. The boy was of muscular build and good nutrition but pale, diaphoretic and writhing in pain. Palpation of his abdomen caused moderate pain with questionable localization to the right lower quadrant. Bowel sounds were decreased.

Urinalysis revealed: sp. gr. 1.025; protein negative; glucose negative; RBC none; WBC occasional. Blood count: hemoglobin 17.0 gm; hematocrit 50%; WBC 19,650; bands 5; segs 82; lymph 7; monos 5.

The picture was not that of appendicitis. The house staff was reminded of Case 1 which was famous by this time. One does not make such a diagnosis twice a year; one would be rash to make that diagnosis twice in a lifetime. With this reservation we explored this patient's abdomen through a McBurney incision. The normal appendix was removed, 1500 cc of serous fluid was duly noted, and the small bowel run for its full length. At this point in the surgical procedure we were prudent enough to avoid the diagnosis of condom obturation but wise enough to seek a bowel obstruction. A globular foreign body plugged the mid ileum causing moderate distention proximally. Removal of the mass thru an enterotomy was followed by uneventful recovery.

Further history taking proceeded while the patient was still in the recovery room. Yes, he had swallowed a whole prune the night before. Satisfaction among the doctors. He had, he remembered, swallowed two prunes. Gloom. As the anesthetic wore off he remembered more. He vomited one prune with the first emesis of the morning.

Discussion

The progressive absorption of air leading to an obstructive size mass has been suggested as the pathogenesis of balloon obstruction.[4] While a balloon will absorb intestinal gas, a solid obturator which will not, can just as effectively obstruct the intestine. Furthermore, inflated balloons on Johnson or Miller-Abbott tubes will traverse the whole gastrointestinal tract while free balloons of similar size can be expected to obstruct as in Case 1. Obturators most often pass into the ileum before obstruction occurs which gives an additional clue to the mechanism.

We now present a theory of pathogenesis which is consistent with the observed phenomenon. A globular mass entering the intestinal lumen will always have a disc cross section at right angles to the intestinal flow; no chance rotation of the mass can present a notch or foramen capable of passing fluid. The waves of peristalsis, which close upon the mass and move it along, close the lumen around the mass so that no proximal fluid may pass distal to the foreign body. As the obturator passes into the ileum, the secreting capacity of the proximal tract becomes ever greater. The proximal fluids accumulate, distend the intestine and absorb the peristaltic waves which no longer close the wall against the proximal surface of the obturator.

If this mechanism is the true explanation, aspiration of the proximal fluid should prevent obstruction. As noted, Miller-Abbott tubes will perform in just this manner. The question of the Cantor balloon which did obstruct[3] is also answered since that tube was used for feeding and not aspiration.

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Hypsarrhythmia is a recently described convulsive disorder of childhood with a typical electroencephalographic tracing. The basic etiology varies and is sometimes not known. This is one of the first reported cases due to hypocalcemia.

Hypsarrhythmia Accompanying Tetany of the Newborn

JACK M. TROY, M.D.
Hammond

SINCE the basic description of hypsarrhythmia by Gibbs[1] in 1954, 40% of the cases have not revealed their etiology. The following presentation is that of a patient with tetany of the newborn who showed the typical convulsions of hypsarrhythmia and whose electroencephalogram was typical of hypsarrhythmia. The patient recovered following therapy with calcium and parathormone and the electroencephalogram is now normal.

Case Report

The patient was the fifth child. The mother's first two pregnancies resulted in normal babies; the third had been a four month miscarriage. The fourth baby came late and weighed 4 kilos. Birth weight of this fifth child was 4.3 kilos and the baby was 3½ weeks late. Two siblings had been born with teeth and all the children are now normal, never having had any disturbances in calcium metabolism.

The mother was normal, had a normal pregnancy and took supplements of calcium and vitamins. There were no neurological diseases in the family; however, the mother had had febrile convulsions as a baby. Three weeks after delivery a blood calcium and phosphorus was done on the mother and both were normal.

On the fifth day of life, the baby stopped eating and was listless. This was followed by a general convulsion. Thereafter the baby had many (over 10) convulsions daily. Phenobarbital and syrup of neocalglucon were given. Two days later Similac 60/40 was started and 10 cc of calcium gluconate was given intravenously daily for four days. Because the electroencephalogram showed hypsarrhythmia, (Figure 1) diazepam (Valium) was started. The chart (Figure 2) shows the levels of calcium and phosphorus obtained and the relation to treatment. The convulsions decreased but did not stop until parathormone 50U B.I.D. was started. It was continued for three days and the calcium and phosphorus returned to normal.

Other investigations included normal CBC, normal x-rays of the skull and chest, and normal spinal tap. The blood revealed Na-141, K-5.2, CL-97, alkaline phosphatase 5.6, fasting blood sugar 78, and the blood urea nitrogen 12. FeCl, PKU, and dinitrophenylhydrazine tests on the urine were negative. The baby went home well and a second electroencephalogram (Figure 3) at 11 weeks of age was perfectly normal.

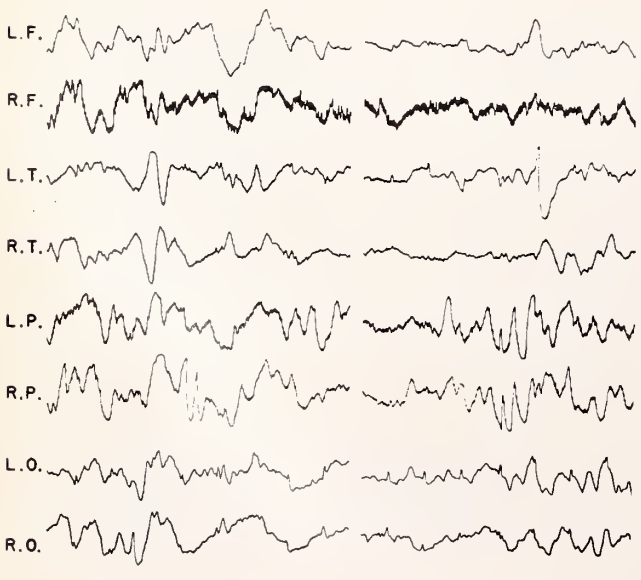


FIGURE 1
EARLY hypsarrhythmia (neonatal form).

Discussion

A comprehensive description of hypsarrhythmia is found in an article by Gibbs[1] in which the electroencephalographic tracing is described as "very high voltage random slow waves and spikes in all cortical areas" (Figure 4). The clinical attacks are short with sudden jerking of the head, rolling up of the eyes, flinging of the arms and quivering of the body.

Organic and metabolic diseases have been associated with hypsarrhythmia;[2] birth injury and encephalitis are most common.[3] Phenylketonuria[4,5] pyridoxine deficiency[6,7] and hypoglycemia[8] have been implicated. The electroencephalographic findings in adult tetany were described by Roth and Nevsimal[9] in 1963. Slow diffuse waves were most common but there was also fast activity with some resemblance to hypsarrhythmia. The

racings returned to normal several weeks after clinical and biochemical recovery.

Summary

A case of hypsarrhythmia due to etany of the newborn is described. Hypsarrhythmia is an electroencephalographic diagnosis, the result of various clinical entities. Among these, etany of the newborn is included. I can find no previous description in the literature.

Acknowledgements

I am indebted to Dr. Fred Gibbs for the electroencephalographic tracings and interpretation and to Dr. J. Gordon Millichap who read the paper.

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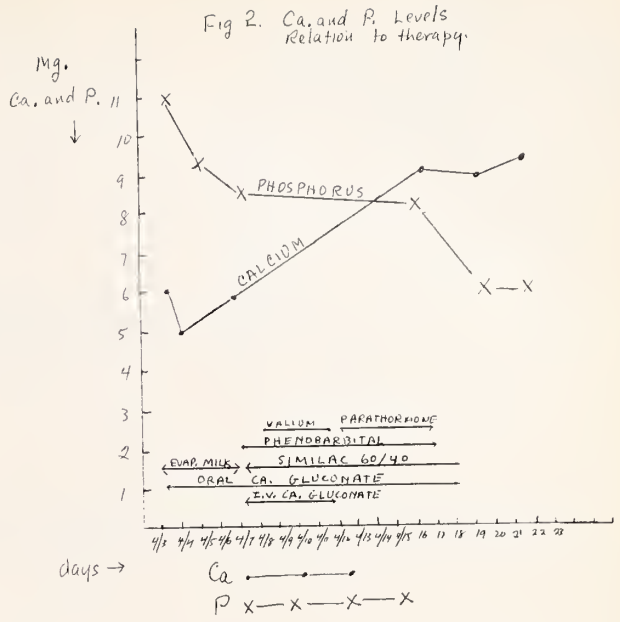


FIGURE 2
LEVELS of calcium and phosphorus obtained and the relation to treatment.

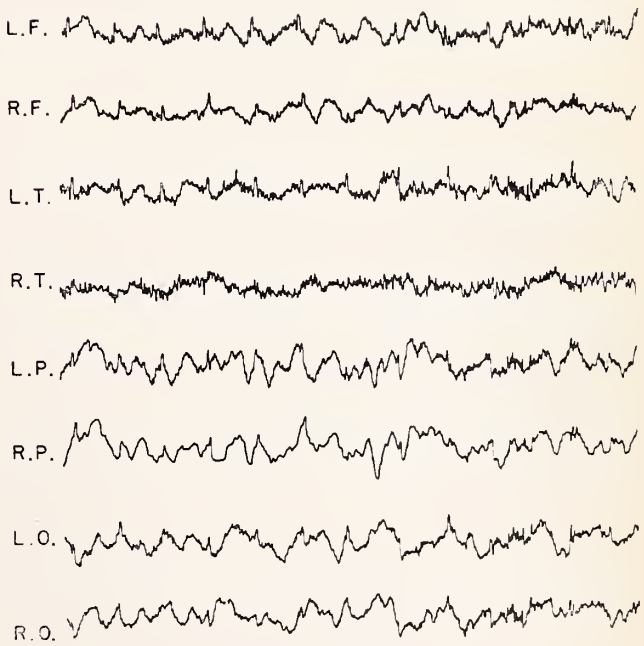


FIGURE 3
WALKING electroencephalogram normal for age 11 weeks.

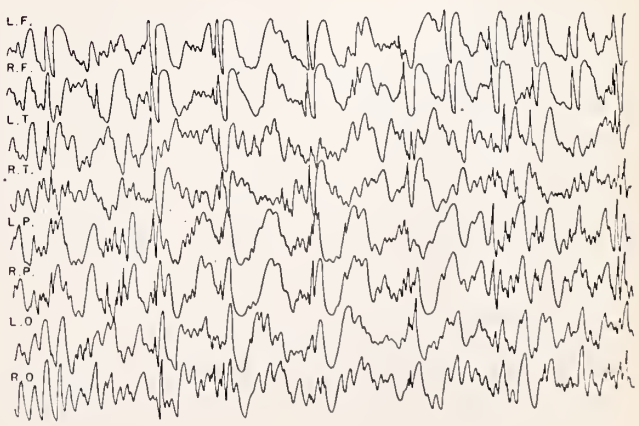


FIGURE 4
HYPSARRHYTHMIA (infantile form).



X-RAY CONFERENCE

Arteriographic Diagnosis of Acute Pancreatitis

*ERICH K. LANG, M.D.**
Shreveport, La.

THIS 37-year-old white female was admitted with complaints of right upper quadrant pain. The clinical history was suggestive of chronic gallbladder disease. A previous cholecystogram had revealed poor function and inability of dye concentration by the gallbladder. Calculi, however, were not demonstrated.

The pertinent laboratory findings at the present admission were significant elevation of the white count with a shift to the left, and elevation of serum amylase. There was no evidence of elevation of urine or serum bilirubin. A repeat gallbladder series demonstrated concentration of contrast medium in the gallbladder after a double dose of telepaque. There was no evidence of radiolucent or radiopaque gallstones nor was there any evidence of obstruction. An upper gastrointestinal barium study was unremarkable with the exception of a rather generous size of the "C loop" of the duodenum.

A selective arteriogram of the gastroduodenal artery was carried out for further assessment of the pancreas (Figure 1). The gastroduodenal and pancreaticoduodenal arteries appeared to be unduly large. The retroduodenal artery, normally an extremely small vessel, was quite prominent and a stain was noted in the area of the head of the pancreas. The pancreaticoduodenal artery in particular suggested slight splaying. The cystic artery was likewise unduly prominent and a stain was identified in the fundus of the gallbladder. The composite findings were interpreted as evidence of an acute pancreatitis with

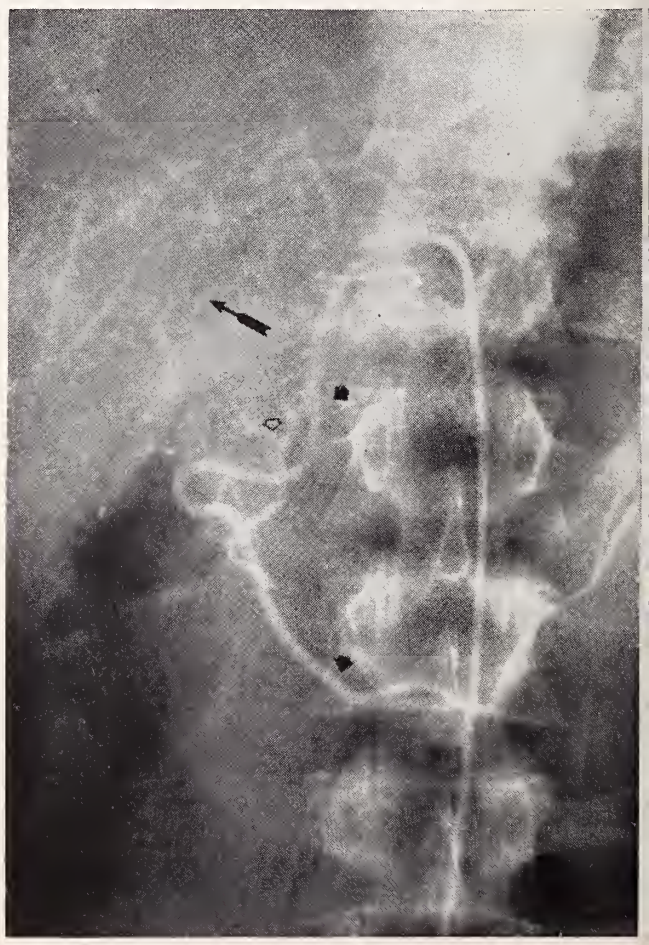


FIGURE 1
A super-selective arteriogram of the gastroduodenal artery demonstrates a large gastroduodenal and pancreaticoduodenal artery (arrows). Note the unusually large retroduodenal artery (lucent arrow). A faint stain and vascular blush is noted in the head of the pancreas. Note the enlarged cystic artery (elongated arrow) and blush in the fundus of the gallbladder suggesting cholecystitis or pericholecystitis. The findings, particularly the splaying of the gastroduodenal and pancreaticoduodenal artery associated with a blush in the head of the pancreas, are suggestive of acute pancreatitis.

* Professor and Chairman, Department of Radiology, Louisiana State University School of Medicine in Shreveport, Shreveport, La. 71106.

enlargement of the head of the pancreas manifested by a sustained vascular stain as well as prominence and splaying of the arteries. The stain in the fundus of the gallbladder and the enlarged cystic artery were felt to reflect evidence of acute cholecystitis and pericholecystitis.

The patient was continued on conservative management and a progressive elevation of serum amylase levels for the next few days appeared to confirm the arteriographic diagnosis. The patient, however, finally recovered on conservative management.

Discussion

Super-selective arteriography of the gastroduodenal artery had first been advocated for the diagnosis of carcinoma of the head of the pancreas. The procedure proved to be disappointing for diagnosis of this entity, however, observation of enlargement of this artery and its radicles and a sustained blush in the region of the head of the pancreas as well as splaying of the involved arteries appeared to correlate to the clinical diagnosis of pancreatitis. The arteriographic findings of increased splaying of the gastroduodenal and pancreaticoduodenal artery, increased caliber size of these vessels and a sustained blush in the head of the pancreas are therefore suggestive for the diagnosis of acute pancreatitis.

Prominence of the cystic artery and a sustained blush of segments of the gallbladder are felt to be indicative of inflammatory disease of the gallbladder. Marked splaying of radicles of the cystic artery has been found to correlate to empyema of the gallbladder.

Arteriographic assessment of the pancreas augments the diagnostic armamentarium attempting diagnosis of pancreatitis, an elusive entity. The method has been found useful to differentiate acute pancreatitis from cholecystitis or other diseases of the biliary tract, occasioning a clinically similar symptom complex. ◄

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The Development and Treatment of Deformity In Pseudoachondroplastic Dwarfs*

RICHARD E. LINDSETH, M.D.
Indianapolis**

PSEUDOACHONDROPLASIA, a term used by Lamy and Maroteaux, describes a category of bone dysplasia which combines the features of both achondroplasia and Morquio's disease.[1] Since the recognition of this type of dwarfism, very few cases have been reported which gives the impression of rare occurrence. However, close examination shows that children originally thought to be dwarfed by achondroplasia or Morquio's disease are in fact affected by pseudoachondroplasia. Characteristically, the child is normal at birth but gradually develops decreased growth of both the spine and limbs so that by the age of two years the stature is very short. The decreased cartilage growth appears to be present only where the epiphyseal plate is associated with a joint, which gives the additional identifying characteristics of normal skull, facial bone and pelvis. In addition to the decrease growth around the joints, the joints themselves become deformed. This deformity, combined with associated ligamentous laxity and muscular weakness makes ambulation difficult and gives the impression of delayed motor development even though intelligence is normal.

Previous investigations have shown that there is a decreased number of chondrocytes, disorderly maturation in the growth plate, and an abnormality of the chondrocyte itself.[2] The presence of muscular weakness and generalized ligamentous laxity also suggests a generalized metabolic defect, particularly abnormal collagen formation. In spite of the abnormal chondrocytes and the probable generalized metabolic defect, the child is able to grow and develop normally in the prenatal and neonatal periods. What happens around the first or second year of life to cause the appearance of abnormal development is not known. Certainly many factors are present during this period of life all of which may have some effect. However, the observation that the greatest growth disturbance occurs where the growth plate is close to articular cartilage and least where there is no associated joint suggests that the stress on the joints caused by increased muscular activity in ambulation may be an important factor. If this is true, then it may be possible to prevent the appearance of the deformities by controlling the stresses on the joint. Two children will be presented to illustrate the development of deformities and the possible effect of early corrective bracing on them.

Case Reports

The first child is an eight-year-old male who appeared normal at birth and had a normal neonatal course. Motor development was somewhat retarded as he sat at seven months, crept on elbows and abdomen at 13 months and walked at 17 months. At this time he walked with a wide base, short right leg gait. Subsequent growth in height was greatly retarded and was associated with progressive disabling bilateral genu valgum. By the age of eight years, he was referred to the medical center for treatment at which time he was severely dwarfed. He had no treatment to the extremities at this time.

On physical examination the child was found to be a severely dwarfed, pleasant boy with normal intelligence. His height was 3 feet, 2½ inches, weight 48 pounds, 3 ounces and arm span 2 feet and 8½ inches. The head appeared normal

* This study was aided by a grant from the Easter Seal Research Foundation of the National Society for Crippled Children and Adults, Inc.

** Assistant Professor of Orthopedic Surgery, Department of Orthopedic Surgery, I.U. School of Medicine, 1100 W. Michigan St., Indianapolis 46202.

without the typical facies of achondroplasia. The neck and spine were short with marked lumbar lordosis and right dorsal scoliosis. The chest and abdomen showed no abnormalities other than a broadening of the chest and flaring of the costal margins. The extremities were very short with marked epiphyseal enlargement and hypermobility of all the joints except for the elbow where there was a 15° flexion contracture. There was a 20° valgus deformity of both knees. Although the muscle bulk appeared normal, there was generalized weakness (Figure 1A & B).

X-ray examination of the spine exhibited rather marked platyspondyly throughout the cervical-dorsal-lumbar spine with the irregularity of the subcondylar bone plate. There was prominent defect of the osseous development of the superior and inferior vertebral body margins giving a tongue-like contour to the anterior aspect (Figure 2). The right dorsal scoliosis measured 21°. The pelvis had a normal contour along the iliac crest and the sacral sciatic notches were open. Subcondylar margin of the acetabulum were very irregular and protusion was present (Figure 3). All of the long bones showed marked shortening with normal caliber of the diaphysis except for the hands and feet. The metaphysis showed marked flaring and irregularity of the subcondylar bone and a 20° genu valgum (Figure 4). The hands and feet revealed severe retardation of the developmental bone age with carpal and tarsal ossification centers showing irregularity of contour.

Shortly after admission osteotomies of the distal femur were performed to correct the valgus deformity of the knees and following bony union, the child was placed in bilateral long leg braces. This child has remained in braces for two years and at last examination had no recurrence of the genu valgum and had gained strength in his legs with decreased fatigue and discomfort.

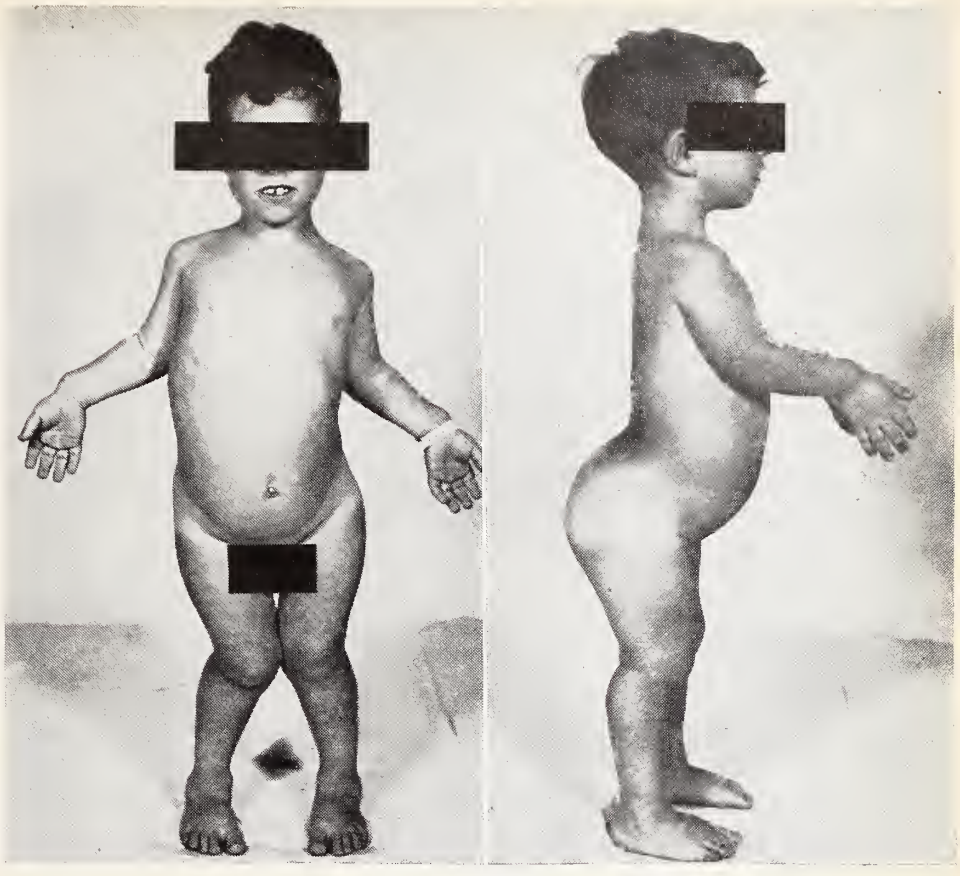


FIGURE 1 (A & B)
(A) Short stature due to both a short spine and extremities, along with laxity of wrists, knees and feet. Marked genu valgus is present. (B) Normal skull and face, straight dorsal spine, marked lumbar lordosis and flexion contractures of the elbows are present (Case I).



FIGURE 2
PLATYSPONDYLY with irregularity of the subchondral bone and step-like anterior defects (Case I).

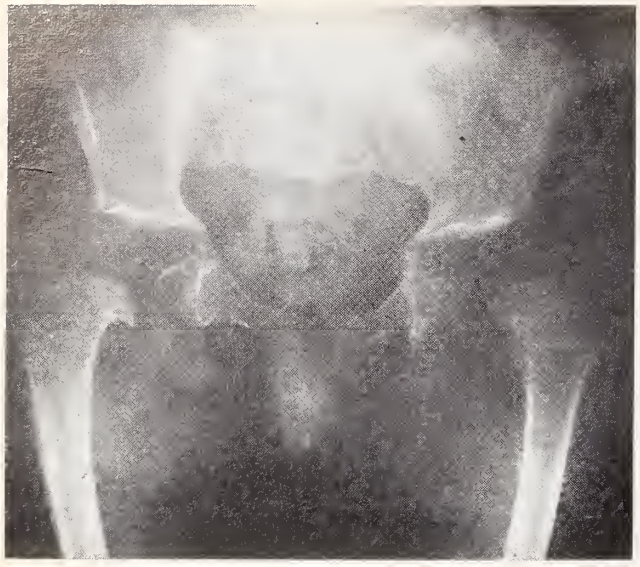


FIGURE 3
NORMAL iliac crests, open sciatic notch, acetabular protrusion, underdeveloped fragmented capital femoral epiphysis and widening of the femoral metaphyses (Case I).

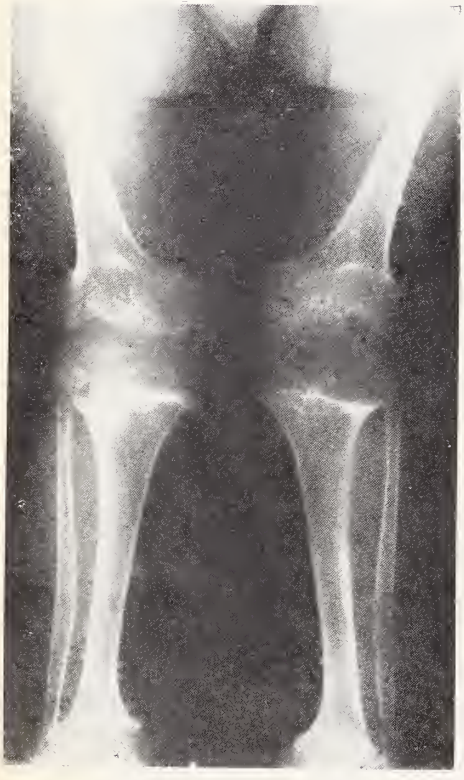


FIGURE 4
GENU valgum, underdeveloped fragmented epiphyses and normal diaphyseal diameter (Case 1).

The second child is a three-year-old girl who had a normal neonatal period with no abnormalities being noticed at birth. Neuromuscular development progressed normally with sitting at age of three to four months and standing with assistance at six months and walking independently at approximately one year. At about 1½ years of age, the mother noticed the child had marked bowing of the legs and also noted inversion of the feet.

Examination of the child showed an active three-year-old who was quite short for her age with a height of 33½ inches. She had approximately 15° varus deformity of both knees with internal torsion and bowing of the tibia. She also had varus deformity of both ankles. Examination also showed muscular weakness and hyperelasticity of her joints with medical instability of the knees, ankles, wrists and fingers (Figure 5A & B).

X-ray examination again showed the slow development of the epiphyseal ossification centers with marked irregularity and flattening of the metaphysis of the long bone similar to the first case. There was 15° genu varus present (Figure 6).

The child was placed in bilateral corrective braces for the genu varum and has worn the braces for one year. During this time, not only has she not had any further development of the deformity but has corrected the genu varum to 10°. She continues to be quite weak although she leads a very active life and does not have any complaints in her lower extremities.

Discussion

These two cases illustrate the classic developmental abnormalities of this type of dwarfism. They are normal at birth but gradually develop decreased skeletal growth and increased joint deformity as age and activity progress so that by the age of two years, a clearly defined growth abnormality is present that progresses until skeletal maturity. The effect that external forces such as weight bearing have on the cartilage is difficult to demonstrate with certainty. However, weight bearing joints, particularly those associated with articular cartilage seem to be more severely involved than the growth centers which are not associated with articular cartilage such as the iliac crest. On this observation it was felt that a trial of lower extremity bracing which would increase the stability of the knees and ankles and counteract the effect of ligamentous laxity should be made.

The use of braces to correct deformity in the growing child is used in many situations. However, the ability to obtain correction and prevent deformity in already abnormal cartilage of pseudoachondroplasia has not been reported. Certainly a brace cannot control all of the forces on the lower extremity during ambu-

lation. However, it was felt that the lateral or medial forces producing the knee deformity could be counteracted and the deformity could be accurately followed and measured to show any progress in treatment. The results indicate that perhaps it is possible to not only keep the deformities from occurring but to also correct the deformity if treatment is begun early. This point will be proven only by more prolonged observation. Because the braces are being used to prevent deformity during growth, it will be necessary to keep the child braced until skeletal maturity.

Summary

1. Spondylo-epiphyseal dysplasia, pseudoachondroplastic type, is characterized by the appearance of skeletal abnormalities of the spine and extremities, which makes its appearance during the first or second year of life and progresses until skeletal maturity.

2. Corrective bracing appears to influence the appearance and development of knee deformity.



FIGURE 5 (A & B)
(A) This child is similar to Case 1 except for the presence of genu varum. Flexion contractures of the elbows, ligamentous laxity, short broad hands, normal skull and face and marked lumbar lordosis are present (Case 2).



FIGURE 6
OPEN sciatic notch, acetabular protrusion, underdeveloped fragmented epiphysis and genu varum (Case 2).

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3. Rubin, P.: Achondroplasia Versus Pseudoachondroplasia, *Radiol. Clin. N. Amer.* 1:621-637, 1963. ◄

From *The Journal* 50 Years Ago

The prostate gland and the neighboring structure, seminal vesicles, utricle, ejaculatory ducts and posterior urethra are one of the great centers of infection in the human body; much more than is usually thought. Every one has associated disease of these structures with gonorrhea or with conditions of hypertrophy of the prostate gland. This viewpoint we know now is erroneous, as hematogenous infection as well as infection by continuity has been observed in the prostate and seminal vesicles many times. . . .

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Another of the commonest complaints of prostatitis is perineal pain. Many of these patients are diagnosed and treated as sexual neurasthenics and told there is nothing wrong with them when in reality they have colon or staphylococci prostatitis of hematogenous origin . . . . V. D. Lespinasse, M.D., Chicago, "Diseases of Prostate Gland and Neighboring Structures," *JISMA*, October, 1919.

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"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.

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We wish to thank Drs. Marcia K. Bilbao, Louis H. Frische, Josef Rösch and Charles T. Dotter for this exceptionally graphic example of hypotonic duodenography.

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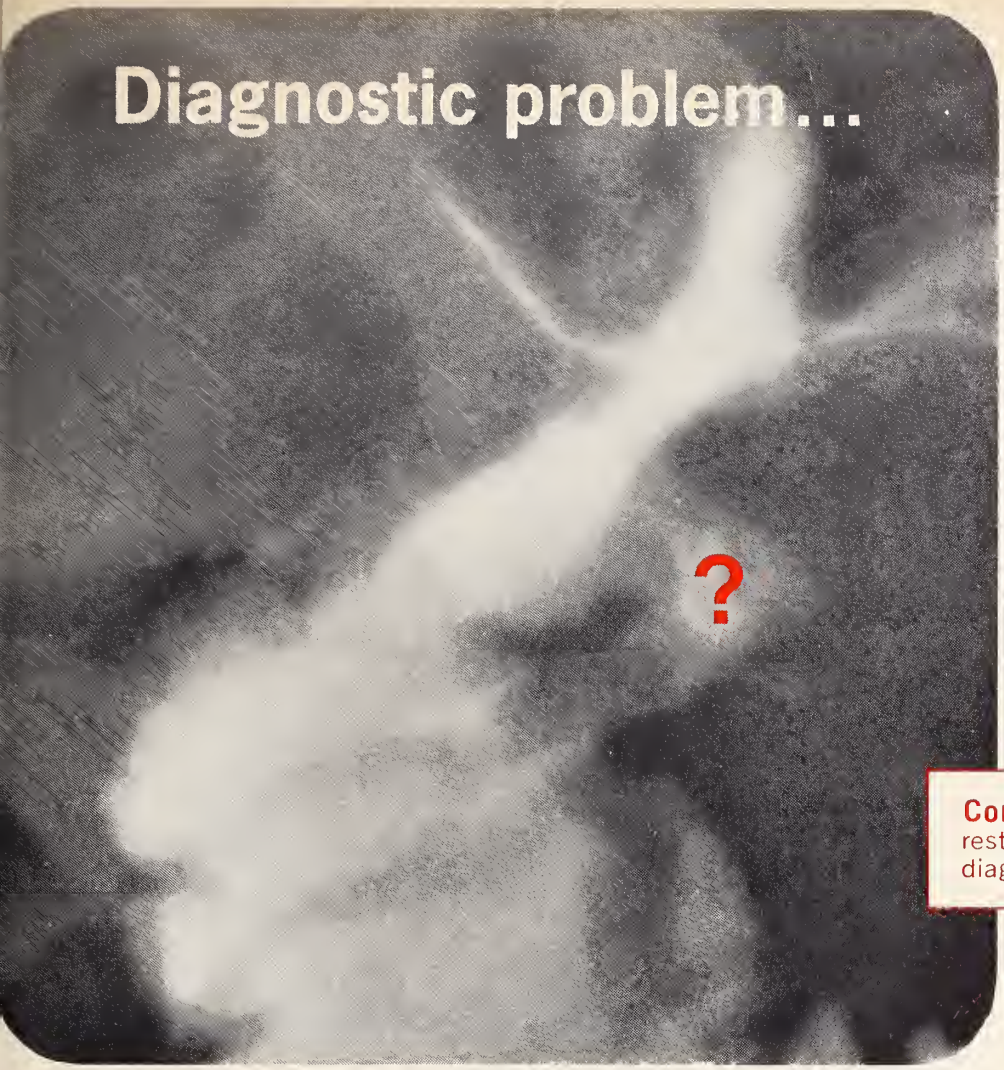
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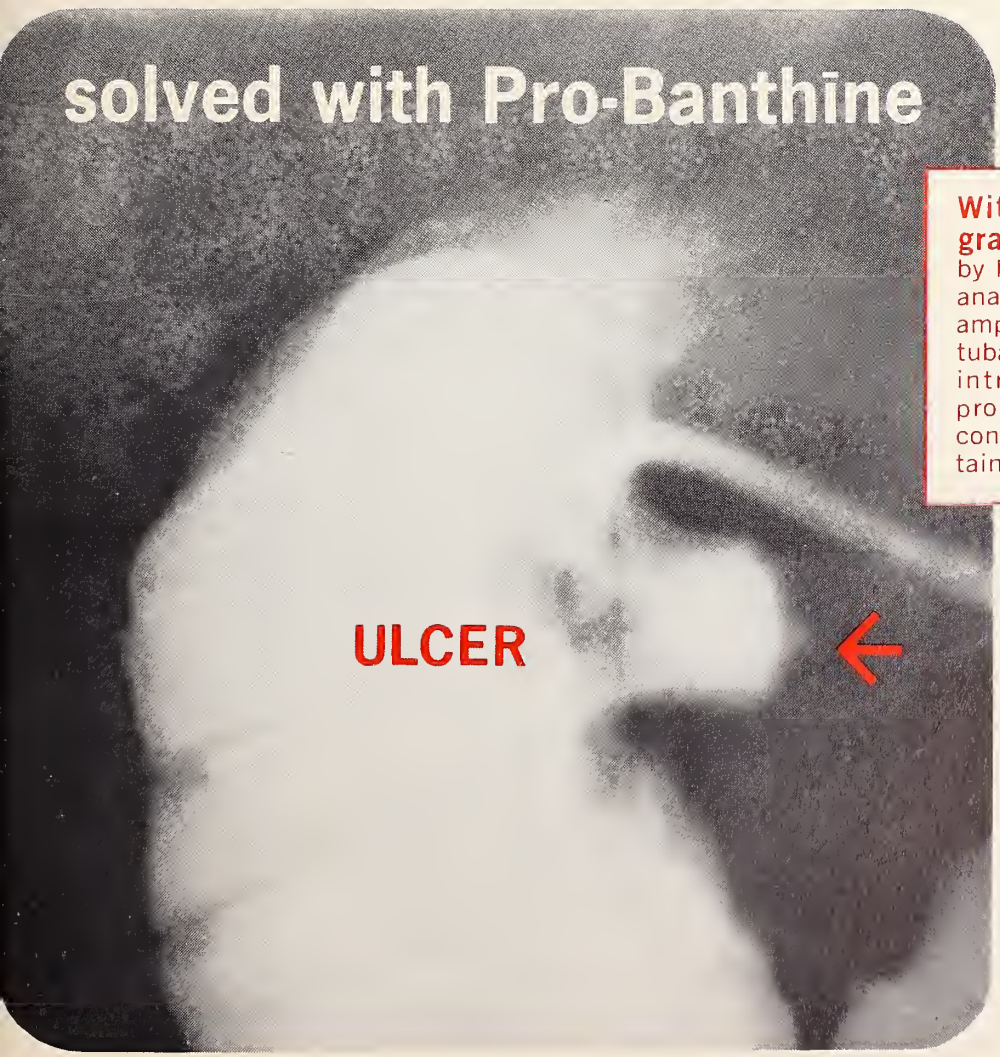
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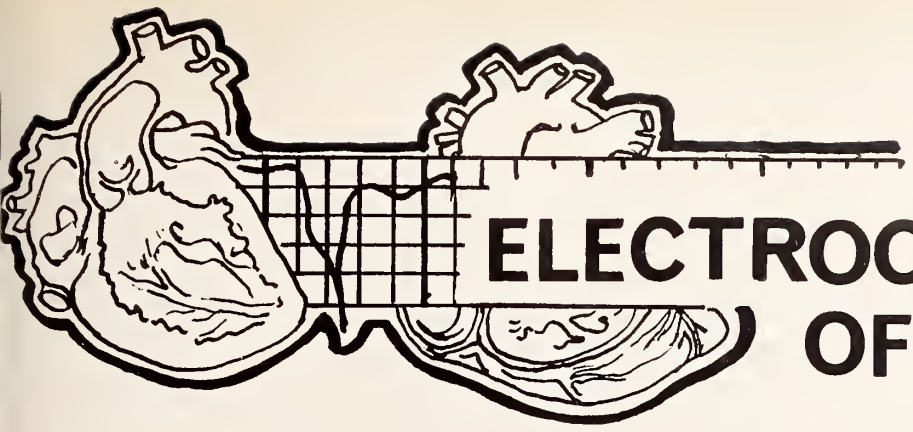
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ELECTROCARDIOGRAM OF THE MONTH

Pacemaker Electrocardiography (111)

CHARLES FISCH, M.D.
*Indianapolis**

IN the previous two issues of this *Journal* we described the ECG features of demand pacemakers with ventricular synchronization and ventricular blocking capabilities. The third type of pacemaker, used largely in the pediatric age group, is the atrial synchronized type.

In this type pacemaker the atrial impulse is transmitted to the pacemaker where it is delayed (pacemaker to stimulus interval) for about .16 seconds, before "discharging" the pacemaker, which in turn excites the ventricles. The characteristic feature is a fixed temporal relationship between the P and QRS (pacemaker artifact). In order to prevent rapid rates, such as may appear with atrial flutter or atrial tachycardia, the pacemaker has a built-in refractoriness and does not as a rule respond to stimuli at rates higher than about 130 to 140 per minute.

The accompanying figure demonstrates (bottom, right side) a 1:1 atrial to pacemaker response at a P-P interval of .44 seconds. At somewhat faster rates (upper strip—left), namely a P-P of .40, the pacemaker fails to respond and results in a 1:1 and 2:1 atrial to pacemaker block. ◄

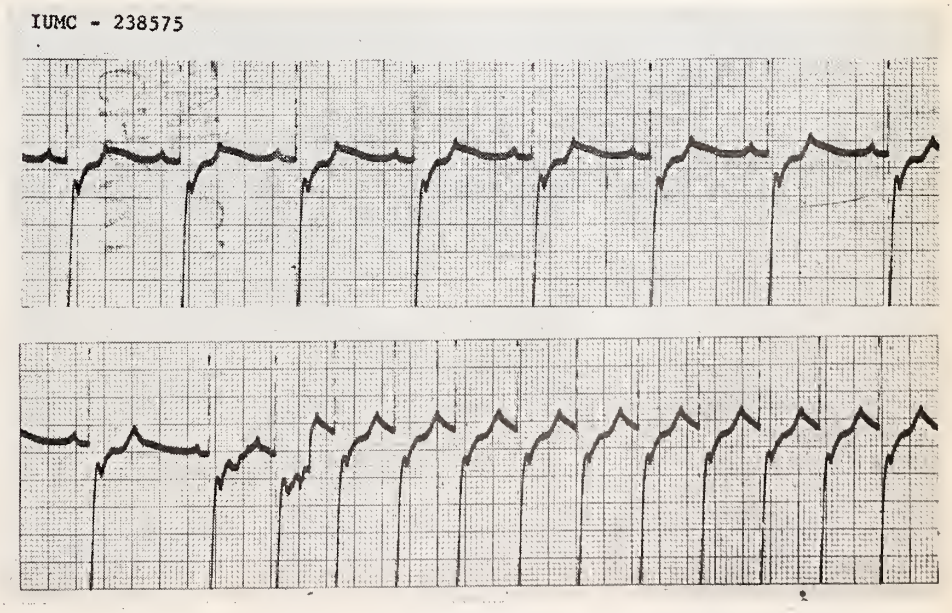


FIGURE 1
ATRIAL synchronized pacemaker. (For details, see text).

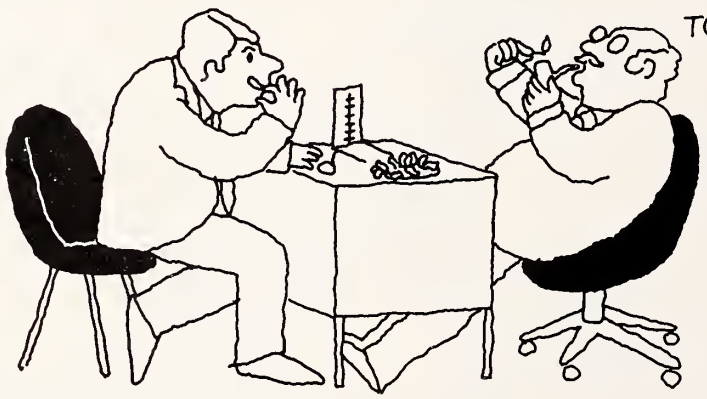
* From the Krannert Institute of Cardiology, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.

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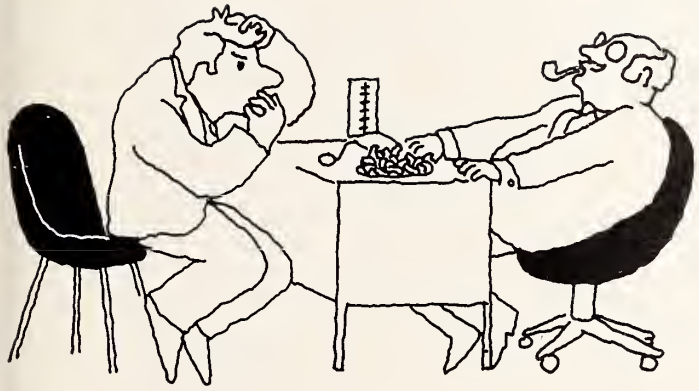


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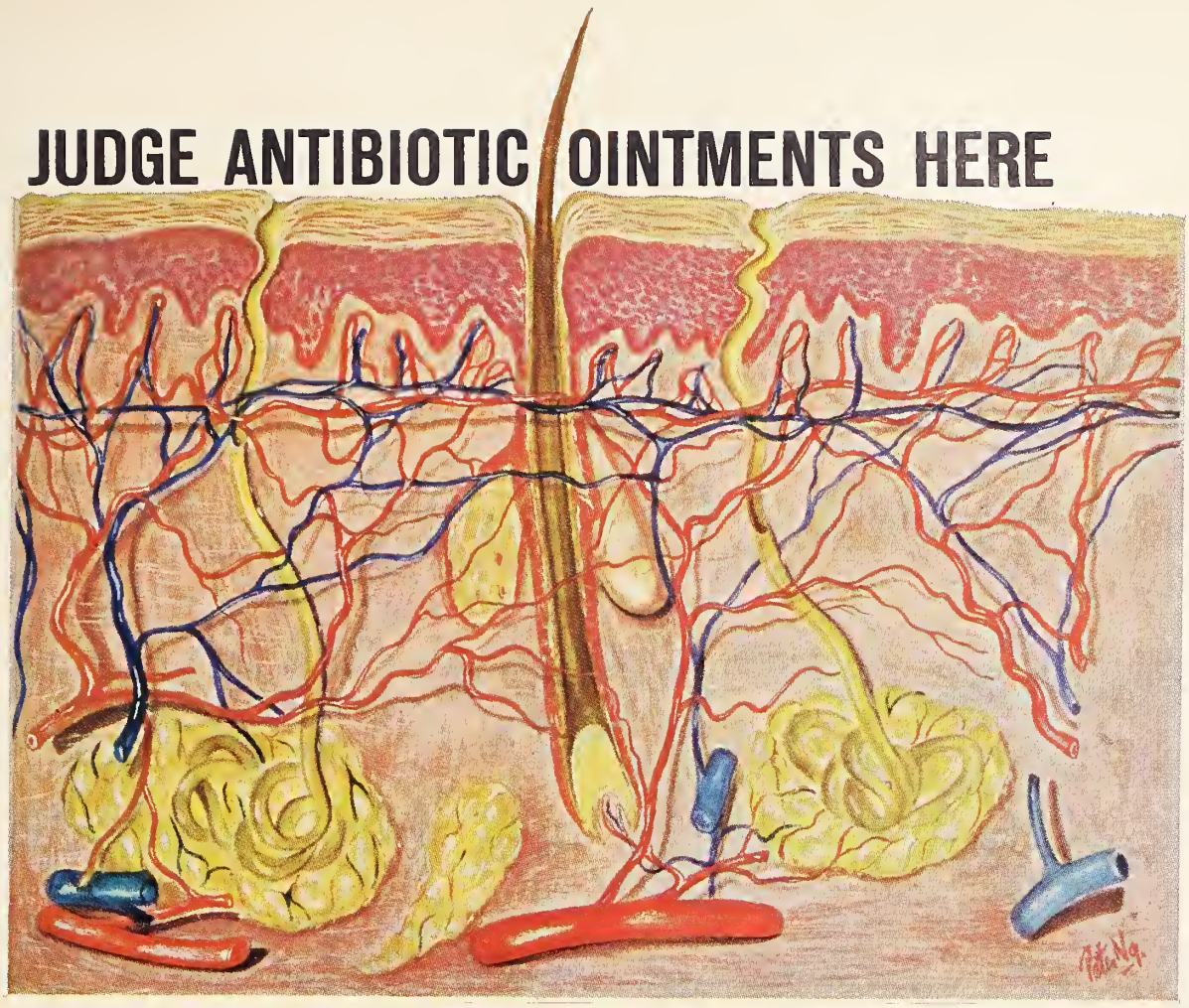
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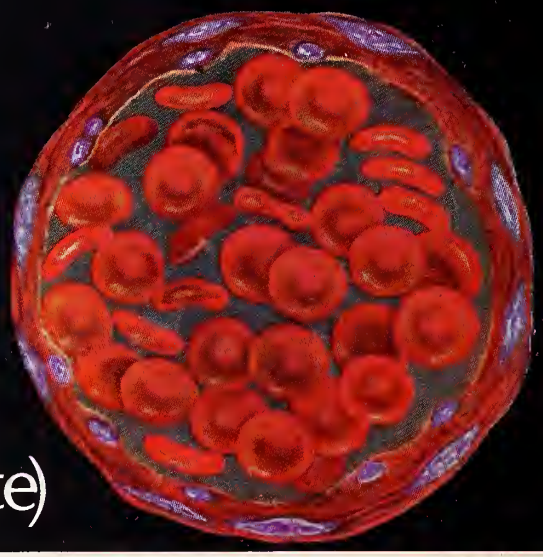
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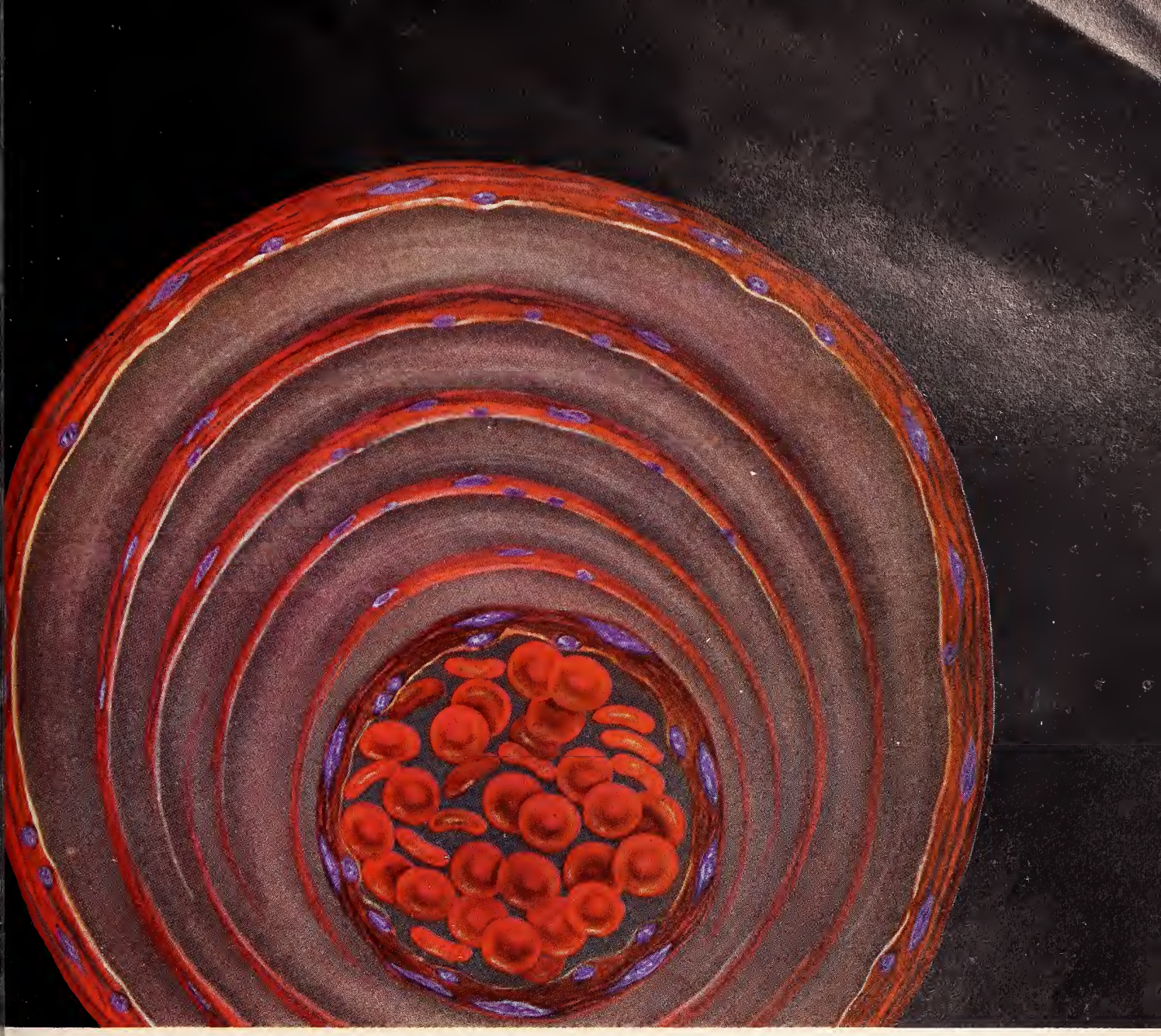
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Prolonged, continuous drug release—Prolonged peripheral vasodilation is provided sustained-release Roniacol Timespan (nico alcohol tartrate) Tablets. Part of the drug be comes available immediately, the remainde continuously over a period of up to 12 hou and dilation of constricted peripheral vesse usually maintained. Thus, with a single dos medication, patients can enjoy the benefits increased peripheral blood flow in ischemi extremities for up to 12 hours.



Smooth peripheral vasodilation from initial dosage...extended with simple, well-tolerated, b.i.d. dosage

The prolonged action of Roniacol Timespan (nicotinyl alcohol tartrate) together with its other benefits offer a therapeutically practical measure in the long-term management of peripheral vascular disease–advantages specially important for older patients.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Conditions associated with deficient circulation; e.g., peripheral vascular disease, vascular spasm, varicose ulcers, decubital ulcers, chilblains, Meniere's syndrome and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

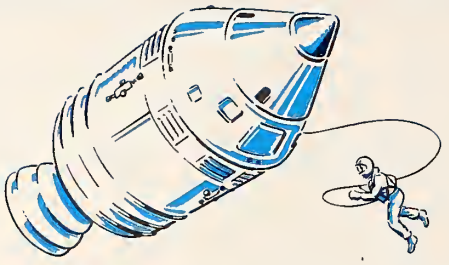
Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt—bottles of 50 and 500.

ROCHE

Roche
LABORATORIES
Division of Hoffmann - La Roche Inc.
Nutley, New Jersey 07110

Art is a conception of peripheral vasodilation.



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, *300 mg.;* SODIUM ACID PHOSPHATE, *500 mg.*

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals

The Journal
of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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Diabetes Detection Week

THE American Diabetes Association and its component organizations, together with medical societies, voluntary health units and cooperating employers, will observe Diabetes Week next month from the 16th to the 22nd. The mission of this annual health activity is to discover the unknown and usually nonsymptomatic diabetic patients of which there are approximately 1,600,000 in the U.S.

Early recognition and early control are so important. Dr. Louis K. Alpert, chairman of the Committee on Public Education and Detection of the Diabetes Association writes:

> "Effective control of diabetes may depend greatly upon early detection. The sooner anyone knows about his diabetes mellitus and brings it under treatment, the better his prognosis usually is. After this, any patient who cooperates can reasonably expect to continue his normal activities and lead a satisfying, productive life."

Actually every physician is interested in detection of diabetes. Every week is Diabetes Detection Week. Every day of the year is Diabetes Detection Day. Diabetes Week offers an opportunity for public education campaigns and for the mass use of the Dreypak urine-sugar test.

Communities that are not able financially to participate in the Diabetes Week program will be aided by a grant from Chas. Pfizer & Company which will supply the Dreypak kit. The Diabetes Association will issue the kits, without charge, to communities who require this assistance.

This will be the 22nd year of the association's work with public education and diabetes detection. Each year has added thousands of diabetic patients, discovered early in their disease, to the host of known diabetics, all of whom are thereby afforded the advantages of modern treatment and control.

Son of Three-Legged Stool

"THE answer is really quite simple" the old grouch began when I next saw him. "All we need to do is to create separate research institutes at the schools of medicine." I asked for further amplification on this thought, because as usual, I seemed to be missing the full impact of the old grouch's proposals.

He claimed that such a proposal would have many advantages. It would bring out into the open the dual role of many on university faculties. It would clearly give the taxpayers an idea of the percentage of public funds that were being devoted to research and to teaching. New faculty members would be employed by only the school of medicine, and their salaries would be for teaching and service. If a member also wished a research appointment it would be considered separately, and his salary could be adjusted from the school and the institute commensurate with the amounts of time he would spend in the two areas. Governmental research grants would go to members of the research institute.

Undistinguished teachers could no longer hide behind their research grants nor would faculty members who are good teachers but poor researchers be forced into research projects in order to obtain grant monies. There would be ample provisions for the physician gifted in both areas to participate in both. In short, the old grouch was only too pleased with what he considered were the multiple advantages of his proposal.

Finding that he had somewhat stunned me with his positive suggestions, he parted with "and furthermore it is the sort of thing that students have been talking about, only in less-garbled language." I was forced to nod in agreement.—**J.W.H.**

Guest Editorials

The Laboratory Question

MANY important questions have been raised by entry of business firms into commercial operation of clinical laboratories. Answering them correctly will not be easy, but it will be important. And the wrong answers, if widely accepted during the current period of clamor for change, could initiate trends no one wants.

Sharp reaction has greeted appearance of advertisements for a commercially operated laboratory in a number of medical journals, including this one. Tenor of the complaints is that laboratory operation is part of the practice of medicine and that commercial firms should not be permitted to advertise in a publication owned and produced by the medical profession.

One of the questions raised by recent appearance of these advertisements was answered by legal action announced just as this issue was about to go on the press. The U.S. Department of Justice and the College of American Pathologists agreed, June 14, to compromise settlement of a suit, instituted by the Department in 1966. The College was charged with alleged price fixing and boycott agreements to keep non-members out of the laboratory business. The consent decree, expected to be made final about a month after the agreement, provides that the College shall not suggest fee schedules and shall not restrict anyone from owning and operating a laboratory. Furthermore, the College has agreed not to impede anyone from accepting advertising or exhibits from any person.

This outcome was anticipated by most of the policy making bodies responsible for journal publication and the anticipation was a large factor in the decision to accept the advertising.

Obtaining answers to another important question is not likely to be any easier or any less painful. Is one who operates a laboratory practicing medicine? From the foregoing, it might be concluded that the answer is *no*. But the question cannot be answered with one word.

It is obvious that one without medical education can set up a laboratory and perform a multitude of tests—a mere matter of training and technique, not of education. The operator can be a Doctor of Philosophy and his results can be precise, but he cannot be practicing medicine.

The criterion cannot be simply the operation of the laboratory and any acceptance of such a principle would be dangerous. The test of the practice of medicine cannot, and should not, be the mere possession of a medical degree and a license to practice. It is not what one has, but what one does, that makes the distinction. The practice of medicine involves care for the patient who is ill, injured, or distraught. Medical care is a complex action for benefit of a complex individual. It cannot be delivered by performing a single act or a series of acts, done routinely as by technicians. A nurse can take temperature, count pulse and record blood pressures, but she is not practicing medicine.

If a physician accepts a sample of blood, makes tests, and reports results to another physician, the first physician cannot be practicing medicine. He has done nothing that a technician cannot do. He has operated a business to serve physicians in practice and conduct of his business does not differ from that of the pharmacist who also serves under the practicing physician's direction. If, however, he obtains a history, examines the patient and confers with the referring physician, he *is* practicing medicine. He is then acquainted with some of the complexities of the patient's illness, or non-illness that cannot possibly appear in a laboratory report. And his advice will reflect his knowledge of medicine as applied to the unique problem of a unique patient.

But there remains the most important question of all—the question of evil when a practicing physician pays a laboratory at rates made possible by modern equipment but charges his patient according to another scale. This is reprehensible practice and should not be tolerated by an honorable profession. The benefits of modern laboratory methods need no elaboration here. They are well known. And there is nothing wrong with any method of laboratory operation that will produce reliable, accurate information. But there is something terribly wrong if the benefits of such operation are not made available to the patient—at cost reflecting economies available.

The ultimate and most important question, therefore, is not who operates the laboratory, or how, but how do we bring the benefit to the patient? The question is not directed toward the ethics of business but to the ethics of the medical profession. The question is for us. We'd better answer it—now.—**Herbert L. Hartley, M.D., Editor,** *Northwest Medicine*, **July, 1969. Reprinted with permission.**

AMA Clinical Convention

THE Mile-High City. The Queen City of the Plains. That's Denver—site of the 23rd Clinical Convention of the American Medical Association.

Colorado's capital gains its nicknames of course from its altitude above sea level and its position at the western edge of the Great Plains near the foothills of the Rockies.

This Clinical Convention, scheduled for Nov. 30 through Dec. 3, is the third to be held in Denver. The most recent was in 1961. The first was in 1952.

Denver is unique in many ways. Its parks system includes 13,448 acres outside the city limits in the surrounding mountain area. (There also are numerous parks within the city and 26 miles of parkways.) Even in

late November and early December, the temperature can climb into the 60s. (But it also can be breezy, and snow sometimes makes a brief appearance, so it's well to bring a varied wardrobe.)

Headquarters hotel for the 23rd Clinical Convention is the Denver Hilton, towering over the downtown area and overlooking the state capitol. (The 13th step on the west side of the capitol is marked by a plaque exactly 5,280 feet above sea level.)

Scientific sessions will be in Denver's convention complex. There are 165,000 square feet of exhibit space, seating for 24,000 and 22,055 square feet of new meeting rooms completed in 1966.

Denver has a population of a half-million, and there are more than a million people in the metropolitan area which includes Denver, Jefferson, Arapahoe, Adams, and Boulder counties.

When snow falls, roads are cleared and sanded promptly, so travel in and around Denver remains uncomplicated for those wishing to explore the sights and activities of this dramatic locale.

The mountains of course are a major attraction. Colorado is the highest state in the union with an average elevation of 6,800 feet. It has 53 peaks above 14,000 feet.

Denver itself has a number of professional and collegiate athletic teams, art and natural history museums, legitimate theater, a symphony orchestra, and a variety of restaurants and night clubs.

Golf and tennis are year-around sports in the Denver area, even in winter when skiers are gliding over Colorado's powder snow only 60 miles away. The front range of the Colorado Rockies is a half-hour drive from downtown Denver, and possible trips include Pike's Peak, the Central City gold mining area, Estes Park, Air Force Academy, Rocky Mountain National Park, and other Colorado cities.

Thus, the Denver area offers the physician and his family a refreshing change. And the professional program planned for AMA's 23rd Clinical Convention offers the physician the very latest in a variety of areas vital to his practice.—**AMA editorial.**

Editorial Notes . . .

The California *Relative Value Studies* which first appeared in 1956, has just had a new edition effective April 1, 1970. The *RVS* is not a fee scale, but sets out on a numerical basis the relative value of a multitude of medical procedures in relation to the basic charge for an office call. In addition to indicating the relative value of procedures, it is helpful to all concerned because it names and identifies all procedures which physicians perform. The new edition lists 50% more procedures than the 1964 edition, and includes a reorganization of some of the sections. Copies of the revised *RVS* are available at $3.50 each by writing Six-Ninety-Three Sutter Publications, 693 Sutter St., San Francisco 94102. Prepaid orders will be filled beginning October 1.

Interim regulations have been published by HEW to set standards for skilled nursing homes. The educational qualifications of nursing personnel in such homes, according to the proposed regulations, will be raised gradually by increments according to calendar deadlines until, by July 1, 1970, the requirements will be at their maximum. Physical specification of homes, as for instance fire protection standards, will be raised in a like manner.

An appellate judge of California has ruled that surgical operations voluntarily entered into for the purpose of sterilization are legal in that state. The Law Department of the AMA took the position in 1961 that voluntary sterilization was legal in all 50 states. The California decision is of importance because hospitals there had been refusing their facilities for sterilization on the grounds that it was "contrary to public policy."

The Veterans Administration will have women as assistant hospital directors. Miss Margaret Michelson, a registered nurse, and Miss Dorothea Seaton, a management analyst, will occupy the number two posts at Salem, Virginia, and Muskogee, Oklahoma. Each of these career women has been with the VA more than 22 years.

The growth of the use of plastic substances in medicine and the research devoted to new uses and new plastics is attested to by the formation of a Medical Review Board by The Society of the Plastics Industry. The board is composed of representatives of 28 companies. It will maintain a clearing house for technical data for physicians. The subject matter will include various uses of prosthetics and implants as well as applications involving disposable plastics.

An aptitude for household chores increases a person's chances of being rehabilitated and active again if he should become disabled. A recent report from Emory University School of Medicine showed that patients with the highest record of participation in household activities before illness were the ones who achieved their maximum level of functional recovery soonest, and vice versa. Recovery appeared to be unrelated to all other factors such as age, sex, race, marital status, social class, employment status and diagnosis. ◄

Pertofrane® desipramine hydrochloride

Indication: Mental depression.

Contraindications: Do not use MAO inhibitors concomitantly or within 2 weeks of the use of this drug. Hyperpyretic crises or severe convulsive seizures may occur with such combinations; potentiation of adverse reactions can be serious or even fatal.

When substituting Pertofrane in patients receiving an MAO inhibitor, allow an interval of at least 14 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.

The drug is contraindicated following recent myocardial infarction and in patients with a known hypersensitivity to tricyclic antidepressants.

Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Due to atropine-like effects and sympathomimetic potentiation, use only with the greatest care in patients with narrow-angle glaucoma or urethral or ureteral spasm.

Do not use in patients with the following conditions unless the need outweighs the risk: severe coronary heart disease with EKG abnormalities, progressive heart failure, angina pectoris, paroxysmal tachycardia and active seizure disorder (may lower seizure threshold).

Desipramine and the parent compound, imipramine, have been shown to block the action of guanethidine and related adrenergic neuron-blocking agents.

Hypertensive episodes have been observed during surgery

The concurrent use of other central nervous system drugs or alcohol may potentiate adverse effects. Since many such drugs may be used during surgery, desipramine should be discontinued prior to elective procedures.

Caution patients on the possibility of impaired ability to operate a motor vehicle or dangerous machinery.

Do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk, and do not use in patients under 12 years of age.

Because of increased sensitivity to the drug, use lower than normal dosage in adolescent and geriatric patients.

Precautions: Potentially suicidal patients require careful supervision and protective measures during therapy. Discontinuation of the drug may be necessary in the presence of increased agitation and anxiety shifting to hypomanic or manic excitement.

Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents).

Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications; transient cardiac arrhythmias have occurred in rare instances.

Periodic blood and liver studies should supplement careful clinical observations in all patients undergoing extended courses of therapy.

Adverse Reactions: The following have been reported: *Nervous System:* dizziness, drowsiness, insomnia, headache, disturbed visual accommodation, tremor, unsteadiness, tinnitus, paresthesias, changes in EEG patterns, epileptiform seizures, mild extrapyramidal activity, falling and neuromuscular incoordination. A confusional state (with such symptoms as hallucinations and disorientation), particularly in older patients and at higher dosage, may require discontinuation of the drug. *Gastrointestinal Tract:* anorexia, dryness of the mouth, nausea, epigastric distress, constipation and diarrhea. *Skin:* skin rashes (including photosensitization), perspiration and flushing sensations. *Liver:* rare cases of transient jaundice (apparently of an obstructive nature) and liver damage. If jaundice or abnormalities in liver function tests occur, discontinue the drug and investigate. *Blood Elements:* bone-marrow depression, agranulocytosis, thrombocytopenia and purpura. If these occur, discontinue the drug. Transient eosinophilia has been observed. *Cardiovascular System:* orthostatic hypotension and tachycardia. Carefully supervise patients requiring concomitant vasodilating therapy, particularly during initial phases. *Genitourinary System:* urinary frequency or retention and impotence. *Endocrine System:* occasional hormonal effects, including gynecomastia, galactorrhea and breast enlargement, and decreased libido and estrogenic effect. *Sensitivity:* urticaria and rare instances of drug fever and cross-sensitivity with imipramine.

Dosage: All patients except geriatric and adolescent: 50 mg. t.i.d. (150 mg. daily). Dosage may be increased up to 200 mg. daily. Geriatric and adolescent patients should usually be started with lower dosage (25 to 50 mg. daily) and may not tolerate higher doses. Dosage may be increased up to 100 mg. daily.

Lower maintenance dosages should be continued for at least 2 months after obtaining a satisfactory response.

Mild anxiety and agitation which may accompany depression usually remit as the depression responds. Occasionally, however, a sedative or tranquilizer may be indicated.

Availability: Maroon and pink capsules of 50 mg. in bottles of 100; pink capsules of 25 mg. in bottles of 100 and 1000. (B)46-530-G

For complete details, please see the full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Coming out of a depression.

And it can often begin to happen in 3 to 5 days with an antidepressant like Pertofrane. There's a lifting of depressed mood . . . a restoration of psychomotor activity. Patients usually begin to cope, work, maybe play, even enjoy.

It's not all beautiful. Sometimes there are side effects. And not everybody can take the drug. It may even be a slow process. But along with the care and comfort you give depressed patients, consider Pertofrane. Then consider the respons

Please read the prescribing information for full details on contraindications, warnings, precautions, adverse reactions and dosage. It's summarized on the left.

Pertofrane®

desipramine hydrochloride

New 50-mg. capsules now available.

It's beautiful!



The Woman's Auxiliary

REPORTS TO ISMA

One of the questions I've been asked over and over is, "What is the function of the Woman's Medical Auxiliary?"



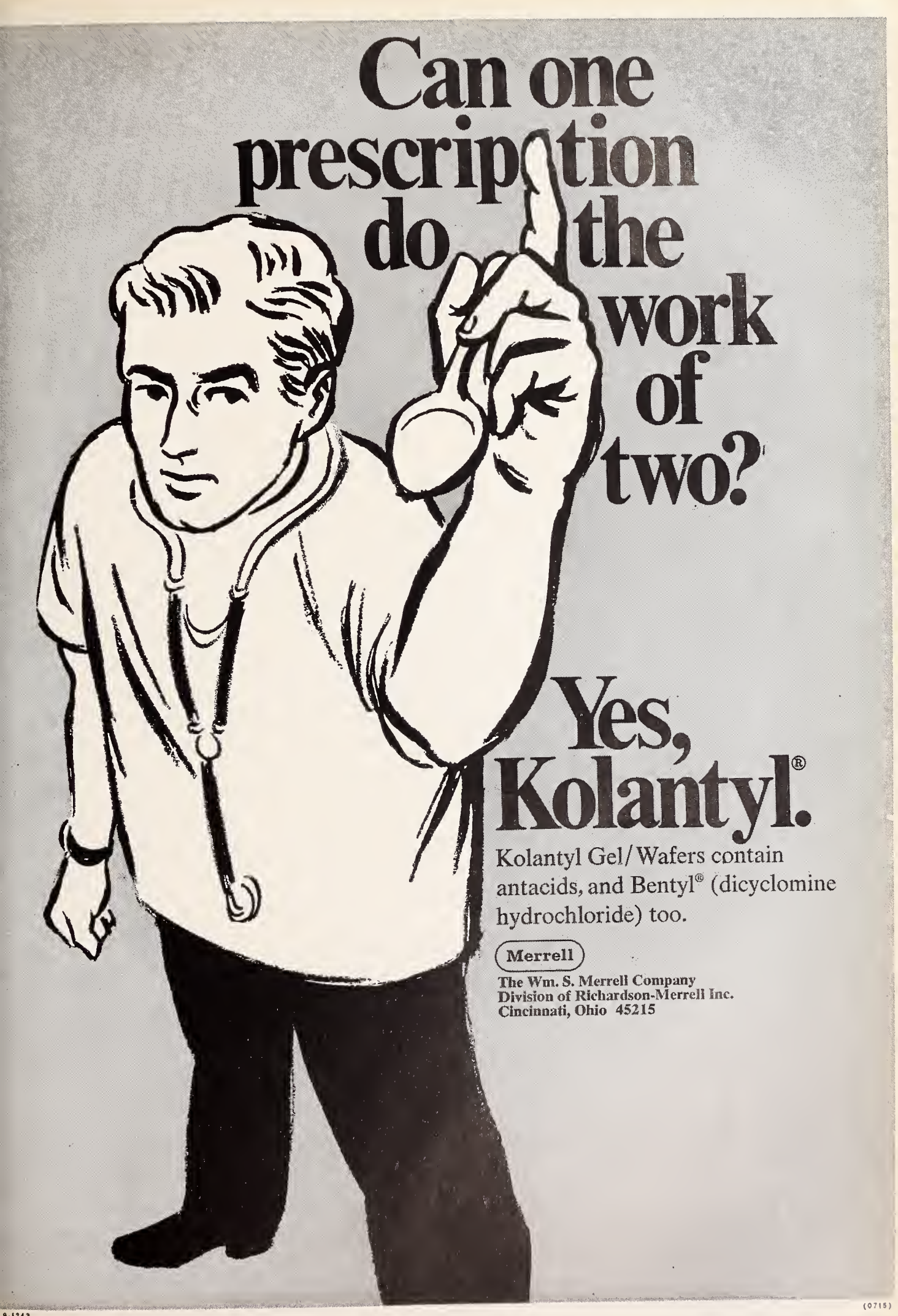
Since a recurrent theme in current discussions of health care and its delivery is the shortage of personnel, my answer always begins with an explanation of AMA-ERF. I tell them that each year medical schools receive monies donated by physicians and members of the Woman's Auxiliary to the AMA. I also explain that the gifts may be designated by the giver for a particular school, but no restrictions are put on how the schools use the money.

This year the record-breaking sum of $428,875.77 was raised by the Woman's Auxiliary to the AMA. This figure represents an increase of some $39,000 over the previous year.

I explain that county auxiliaries have a commendable record of support for both AMA-ERF and health career activities, but that we realize we need to redouble our efforts in both these areas. We know that our doctor husbands are constantly developing new ways to train more personnel in a shorter time, and to use them more efficiently after training.

Therefore, it is our responsibility to do what we can to help furnish financial assistance both to medical schools and to individuals—and to interest an ever-growing number of prospective students and trainees for the health profession.

Sylvia Schneider


Can one prescription do the work of two?
Yes, Kolantyl®.
Kolantyl Gel/Wafers contain antacids, and Bentyl® (dicyclomine hydrochloride) too.
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GLEANED FROM THE BRITISH MEDICAL JOURNAL

JACK W. HICKMAN, M.D.
Indianapolis

Adverse Reactions to Various Drugs

Physicians are generally aware that the medications that are prescribed for patients can result in harm as well as benefit. An article by Hurwitz underscores this fact by demonstrating that a significant percentage of hospital admissions were due to drugs.[1] In a one year survey, she found that five percent of admissions to two Belfast hospitals were drug-related. Roughly three percent of the admissions were because of adverse reactions to various drugs, whereas two percent were because of intentional self-overdosage. A few case reports are given in detail and it is clear that many reactions were of a serious nature. No breakdown as to the frequency of reaction to various classes of drugs is mentioned aside from the fact that barbiturates were the ones most frequently used in suicide attempts. "Primum non nocere" is still with us.

Serial Kidney Studies in Pyelonephritis

Bailey et al.[2] had an unusual chance to follow a patient through an episode of acute pyelonephritis with renal function tests and intravenous pyelograms before, during and after the acute episode. The most striking finding was an increase in size in both kidneys during the acute episode; the right kidney having the greater increase, despite the fact that the patient had bilateral symptoms. Furthermore, the right kidney did not demonstrate any excretion of contrast material. Nine days after hospital admission, the right kidney was shown to be excreting contrast material on a repeat examination, although not as well as the left kidney. A repeat pyelogram three and one-half months after the infection showed bilateral dye excretion, but the right renal shadow was now 1 cm. shorter than the pre-pyelonephritis pyelogram. The initial diagnosis of pyelonephritis had been confirmed by renal biopsy. Films such as these certainly demonstrate graphically that renal mass is indeed lost with episodes of pyelonephritis. It is not hard to visualize that a similar, but slower process, can take place with chronic infection.

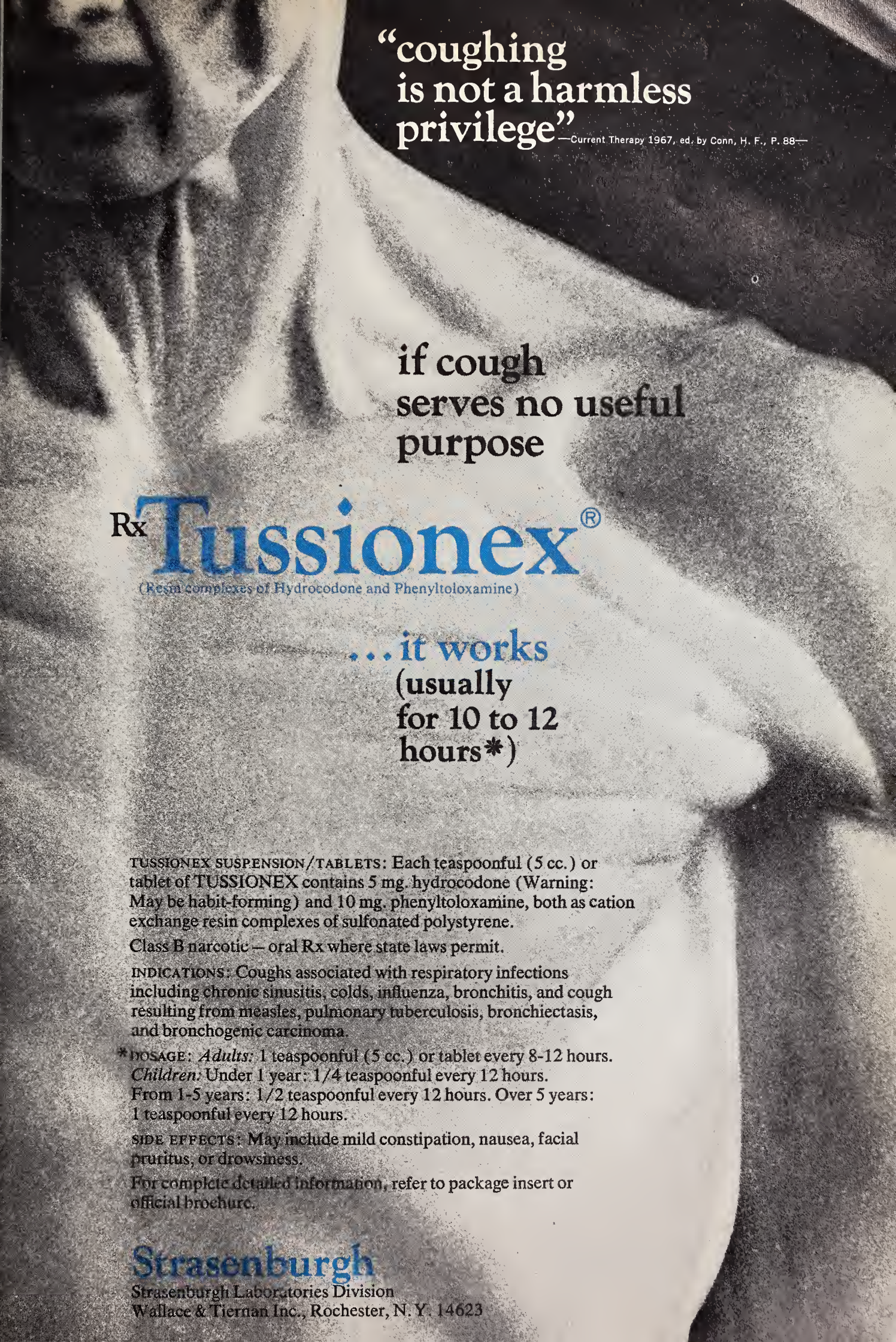
Adults Wilt with Diseases of Childhood

It often does seem that children handle children's diseases far better than adults do. Another example of this truism is reported by Tapp,[3] in which he reports the spontaneous rupture of a spleen in an adult suffering from chickenpox. The patient was a 25-year-old healthy male who was admitted in shock with pain in the left side that came on spontaneously, and could not be related to trauma. This episode came on seven days after the onset of a typical chickenpox rash. Splenectomy was performed, and the patient made an uneventful recovery from both the splenic rupture and the chickenpox. As the author mentions, most of us associate the above series of events with infectious mononucleosis, and even then we would expect it to be associated with some trauma. A rare occurrence, to be sure, but cases such as these alert us to treat adults who contact children's illnesses with respect.

* * *

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2. Bailey, R. R., et al.: Renal Damage after Acute Pyelonephritis, *Brit. Med. J.* 1:550-551, No. 5643.
3. Tapp, E.: Ruptured Spleen Associated with Chickenpox, *Brit. Med. J.* 1:617-618, No. 5644. ◄



TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.

Class B narcotic — oral Rx where state laws permit.

INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

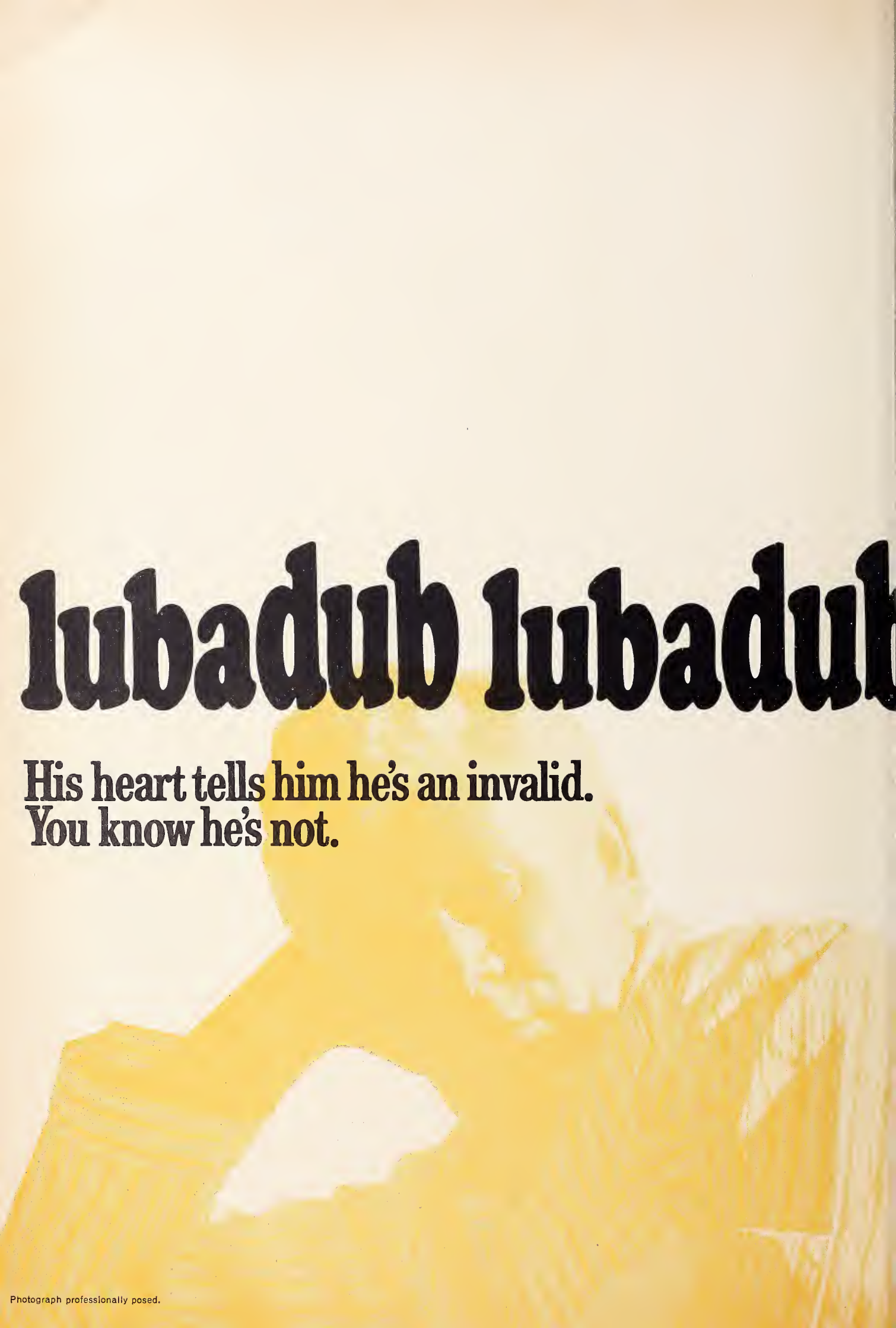
For complete detailed information, refer to package insert or official brochure.

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lubadub lubadub

His heart tells him he's an invalid.
You know he's not.



Photograph professionally posed.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis,

ubadubdub lubadu

Anxiety is expected in the cardiovascular patient. A little may even be desirable.

But when anxiety is exaggerated . . . when it interferes with sleep . . . when it aggravates cardiovascular symptoms, your help may be needed.

Naturally, you'll want to reassure the patient.

And perhaps prescribe Equanil (meprobamate) as adjunctive therapy. It helps relieve anxiety and tension specifically, yet gently.

Almost 15 years' use has shown that Equanil is usually well tolerated as well as effective. Side effects are generally limited to transient drowsiness; serious, therapy-interrupting side effects are rare.

stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

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(meprobamate) Wyeth®



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Terramycin®
(oxytetracycline)

An infection of rapid onset requiring prompt attention. Teenage girl with chills, fever, abdominal pain, backache and nausea. Frequent and urgent urination with burning. On examination—tenderness over kidney. Blood count and urinalysis confirm the diagnosis: acute pyelonephritis. Treatment is initiated with Terramycin. Within a few days of follow-up therapy, the patient is markedly improved. The pretreatment urine culture shows a strain of *E. coli* highly susceptible to Terramycin.

Experience has shown that Terramycin offers special advantages in treating urinary tract infections when strains of causative bacteria are susceptible. Broad-spectrum coverage unaffected by penicillinase. Effective tissue levels to help reach foci of infection in renal parenchyma. High urine levels—excreted by kidney in *active* form.

With Terramycin, you have the assurance that comes with choosing an agent physicians have depended on for over 18 years. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Contraindicated: In individuals hypersensitive to oxytetracycline.

Warnings: Reduce usual oral dosage and consider antibiotic serum level determinations in patients with impaired renal function.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight; if such reactions occur, discontinue therapy.

Note: With oxytetracycline, phototoxicity is unknown and photoallergy very rare.

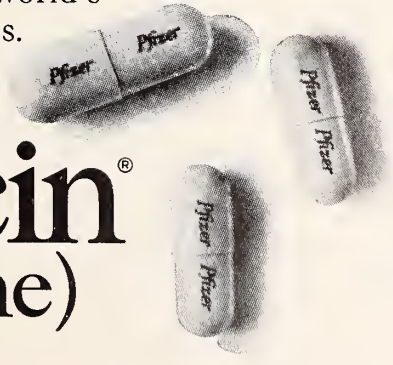
Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy. Increased intracranial pressure in infants is a possibility. Symptoms disappear upon discontinuation of therapy.

Adverse Reactions: Nausea, diarrhea, glossitis, stomatitis, proctitis, vaginitis and dermatitis, as well as reactions of an allergic nature, may occur but are rare.

Supply:* Terramycin Capsules: oxytetracycline HCl, 250 mg. and 125 mg. Terramycin Syrup: calcium oxytetracycline, 125 mg. per 5 cc. Terramycin Pediatric Drops: calcium oxytetracycline, 100 mg. per cc.

*All potencies listed are in terms of the standard, oxytetracycline.

More detailed professional information available on request.



Terramycin®
(oxytetracycline)

Pfizer LABORATORIES DIVISION
New York, N.Y. 10017

The Katherine Hamilton Mental Health Center

A. W. CAVINS, M.D.
Terre Haute

THE new community mental health center, about to assume solid, physical form at Terre Haute, will serve six counties, comprising Region VII, namely: Clay, Greene, Parke, Sullivan, Vermillion, and Vigo, with a combined population of well over 200,000. One hundred forty citizens of these counties served on a Regional Planning Committee, organized in 1964. They accumulated data later used by a smaller executive committee, under the chairmanship of Betty Dukes, M.D., a Sullivan County physician (and well known to the ISMA), to compile a plan for Region VII. This plan was approved by the Indiana Department of Mental Health and subsequently was readied for implementation by a steering committee for Region VII, chaired by Mr. James Conover. The work of this committee pointed up the need for a director of development, and Mr. Joseph Mackey was employed to pilot the proposals through the complex area of finance and organization.

The Katherine Hamilton Mental Health Center will occupy land next to the Union Hospital and will use some of its facilities, such as laundry, food service, x-ray, pharmacy, medical records, and certain business and accounting office service, emergency room, and clinical laboratory (this last through the hospital's pathologist). Thus, by having the mental health center adjacent to the hospital, duplication of the shared services will be avoided, but the center will remain a separate corporate entity. Inpatient and outpatient therapy will be provided both by a hired staff and by private practitioners of medicine of Region VII, organized as an open hospital staff.

The center will have a medical director who is a psychiatrist, and Dr. William C. Shriner has been appointed to this post. Since August 1 he has been practicing psychiatry in Terre Haute, is the medical director of the Adult and Child Guidance Clinic, and is also acting as consultant to the Katherine Hamilton Mental Health Center Board during the establishment of the center. He will then continue as medical director of the Katherine Hamilton Mental Health Center. Dr. Shriner is a native of Terre Haute and a graduate of Garfield High School, Indiana State University, and Indiana University School of Medicine (1962). Since 1965 he has been in residency training in psychiatry at Indiana University Medical Center, including service at LaRue Carter Hospital, the Long Adult Psychiatry Clinic, Marion County General Hospital, University Student Health Service (Bloomington) and the Riley Child Guidance Clinic.

Effective Elements

There will be four elements cooperating to form the center. Three of these—the Adult and Child Guidance Clinic, Inc., the Vigo County Mental Health Association, and the psychiatric unit of Union Hospital, Inc.—were originally established by Miss Katherine Hamilton, who devoted her life to the mentally ill, and who left a substantial bequest for the furtherance of mental health activities. The center is therefore named in her honor.

The fourth agency to be linked with these three is the Family Service Association. This group dates from 1882, when it began as the Society for Organizing Charity (in Vigo County), becoming in 1935 the Family Welfare Society, and in 1956, the Family Service Association.

In 1959, the Adult and Child Guidance Clinic was founded and in 1963, Dr. Betty Dukes engineered the expansion of this to include other counties. Largely for this work she received the award of the Indiana State Mental Health Association of "Physician of the Year" in 1966.

In 1950 the Vigo County Mental Hygiene Society was formed and about 1955 changed its name to the Mental Health Association of Vigo County. Union Hospital, Inc. was opened originally as the Terre Haute Sanitarium in 1892, a private hospital, later becoming a community hospital. In 1957 a local benefactor left a bequest to establish a psychiatric unit in each of the two Terre Haute hospitals. By agreement between these hospitals, Union Hospital accepted this opportunity and installed a psychiatric facility, chiefly for acute cases.

Designed for Flexibility

The new building was designed for maximum flexibility, allowing for future expansion and modification, by David J. Field of Ewing Miller Associates. It will consist of two stories and will provide approximately 45,000 square feet of working space. The first floor will house outpatient services, staff offices, playrooms, group therapy rooms, social workers' offices, and a dining area. The second story will include a 40-

bed inpatient unit, in which the majority of the rooms will be for double or single person occupancy. At the end of one wing of the second floor, there is to be a six-bed children's section, with play area, which can be closed off as a separate unit. In another wing there will be a similar area of four rooms which can be separated, as required, for a secure area. Owing to land contour, the second floor will be at ground level at one end, allowing easy access by inpatients to outdoor recreation and activity space.

Bids for the building are to be received October 21, with completion scheduled 15 months after the contracts are signed. This will be the first such center in Indiana and one of the earliest in the United States. Financing of the $2,250,000 facility will be shared, the Federal government funding 50% of the total cost, state funds providing 25%, and local sources in the six counties (partly tax levies and partly private subscriptions) supplying 25%. The campaign in 1967-68 to raise funds in the six counties was headed by William G. Bannon, M.D., of Terre Haute, who later received the "Physician of the Year" award of the Indiana State Mental Health Association for 1968.

Katherine Hamilton was active in improving conditions for the mentally ill for over 33 years, to the time of her death in 1961. Included in her service career were six years as a medical social worker at the University of Chicago's clinic, and three years on the staff of Union Hospital School of Nursing as a teacher. In addition to her strong aid in establishing three of the agencies of the new center, she served the Indiana Association for Mental Health for ten years as board member, secretary, and delegate to the National Association for Mental Health. She was largely responsible for stopping the practice of jailing mental cases in Vigo County and encouraged other Indiana counties to do the same. The Indiana Mental Health Memorial Foundation gives an annual award called "The Katherine Hamilton Award" to an individual who has provided outstanding service to the mentally ill and who has a close relative in a mental institution. Katherine Hamilton's older sister had to be committed for schizophrenia at age 27, and this determined Katherine's career.

Local Assistance

The functions of the Union Hospital and of the County Mental Health Associations should be well known to our readers by analogy with comparable organizations statewide, but the other two elements of the new center have developed locally with no "outside" connections. The Family Service Association acts and serves at the preventive end of the welfare spectrum. It has a director plus three social workers on the staff who do family counseling. Its relationship with the other agencies to be in the center is reciprocal. The Vigo County Adult and Child Guidance Clinic works on an outpatient ambulatory and home-visit basis directly with the mentally ill, including alcoholics. It is staffed by an executive director, one psychologist (full time), one psychiatrist (part time), three full time and one half-time social workers, a counselor on alcoholism, an office manager, and a clerk-typist—with one position open for a full time social worker. The Vigo County Mental Health Association has an executive director, and a secretary, both full time. It is a lay organization which provides: education, planning, "trouble-shooting" service, and a link between state hospitals, patient's families and the community. It has nine committees through which many lay persons carry on the work just mentioned. This agency has in several instances recognized an unfilled need in the community; has helped to form an organization to cope with the need; and then has itself withdrawn from that particular field.

These local agencies have long had a close working relationship which should assure smooth operation of the new mental health center from the beginning. The center will start with the five services considered essential to a comprehensive mental health center:

1) inpatient service,

2) outpatient service,

3) twenty-four hour emergency service,

4) part-time hospitalization,

5) education and consultation.

These are required in order to provide the patient with continuity of care, whether at his home, at the mental health center, or at a state hospital. Hopefully, there will also be a research program, the first project to be supported by a grant from the National Institute of Mental Health and to be concerned with a study of therapeutic environment in relation to behavioral patterns. This grant is now under consideration.

The medical profession of Indiana will watch the progress of this institution (and any similar ones) with keen interest, and, need we say, *support*. It is an example of what can be accomplished at the local level by private citizens who are sufficiently motivated and who have developed good leaders.

221 S. 6th St.
Terre Haute ◄

(Architect's concept on the cover courtesy Ewing Miller Associates, Terre Haute).

Tyrannical Taxation

A. G. BLAZEY, M.D.
Washington, Ind.

BECAUSE of oppressive taxation without representation, our forebears founded a new nation dedicated to the principle of maximum individual liberty affording the greatest opportunity for personal incentive towards continued improvement.

That was back in the eighteenth century. Now we have oppressive taxation with dishonest representation which has run rampant for the past 35 years to the extent of making this republic the biggest debt-loaded nation in the world.

What has happened, in less than 200 years, to the healthy spirit of independence that created the most industrious and best form of government the world has yet known? Why have we not had vociferous objections by a majority of workers for the theft of the fruits of their labor by a government whose actions indicate not only wanton violation of basic law but also a consistent disregard for moral law?

A significant proportion of doctors signed the Declaration of Independence. An insignificant number of doctors are now objecting to excessive taxation by representatives who violate their oaths of office with impunity, and tax collectors who devise their own laws to fleece their sheep.

Last year the I.R.S. cracked down on a doctor in Illinois who had set up a tax-free foundation along the same lines that have allowed the Ford Foundation to exist for 33 years. That doctor was trying to avoid excessive taxation—but, he was not a member of the Council of Foreign Relations and his objective was not to subvert this nation into a one world government! He was only trying to protect the fruits of his own labors within existing laws which apparently do not apply to conscientious individuals in lower income brackets.

Then there's the courageous example of a Florida doctor who has refused to pay exorbitant income taxes for a multitude of profligate money-squandering plans enacted by an inept Congress.

In the nineteenth century, Herbert Spencer wrote a book entitled *The Man Versus The State* because even then, in the 1880's, legislators were proposing laws that needlessly restricted the freedom of action of the British people. Even in that day legislators were proposing compulsory social security which was hung, like an albatross, around our necks in 1935. Spencer referred to the "political momentum" wherein the state augmented all intrusions into what had previously been the private affairs of men. At this point, meditate upon the intrusion of the Census Bureau from its original intent to tabulate the number of people in the country to its current desire to have a full dossier of information about the living habits of every tenth person!

You might also recall that the Ruml Plan to allow the government to steal money from a worker's paycheck before he received it was passed as an emergency war measure back in the 1940's. It's still with us!

So Spencer said in 1884: "The more numerous public instrumentalities become, the more is there generated in citizens the notion that everything is to be done for them, and nothing by them. Every generation is made less familiar with the attainments of desired ends by individual actions or private agencies; until, eventually, governmental agencies come to be thought of as the only available agencies."

Political Boondoggles

With this brief historical prologue in mind, cast an eye on the multitude of political boondoggles that have increased in our land with the momentum of an Apollo 8 leaving the launching pad of spiraling taxation since 1935. Is it not past time to stop these unconstitutional trespasses that are the cause of our current astronomical debt?

Yet, in current years, even the "leaders" of medicine are advocating more federal monstrosities such as Medicare, Medicaid, O.E.O., R.M.P. and Comprehensive Medical Care. Don't these "leaders" know the meaning of debt? Don't they know that deficit financing of thousands of boondoggles since 1935 has cut the value of our dollar down to a quarter with the skids still under it?

Many people are being hoodwinked by the latest gambit of this nation's "hidden rulers" as they devise plans, to become laws, which will merely shift many current boondoggles from the government sector to the independent sector. What is the independent sector? It is comprised chiefly of the following: tax-free organizations, foundations, labor unions and churches—plus cooperations and mutual life insurance companies that have special tax exemptions. Such a switch would not take any tax load off the back of the average worker who belongs to the private sector. Of course the public sector is the one who collects and spends all the tax money provided only by the private sector—the one in which you and I and tax paying corporations belong.

Volunteers are needed now more badly than they were needed in 1776 to stop, at this time, excessive taxation by men who refuse to represent their constituents—men who continue a policy of taking from the "haves" to give to the "have nots." This "legalized" theft must stop and the only way it will be stopped is by a full exposure of the connivers

bent upon world-wide control of you and your life savings.

Start Objecting

If you're weary now from working three months out of each year to support the immoral demands of a welfare state, you'll be utterly fatigued to have that slave labor time doubled, if you don't now start objecting.

For those who do not know how to object, I would suggest a close study of the Constitution of the U.S.A. and its amendments to date. When any legislator acts contrary to that document, you should let him know about it. When sufficient citizens accept that responsibility we may be able to keep our representatives in line with their oaths of office.

Read our Constitution and understand its speeific language. When it is violated by any proposed law you should object fast and positively. What's more, you should influence other people to do the same. To remain silent when you should object makes cowards of men.

You can make your objections known to your patients by direct comments upon the evils of federal medical care programs, urban renewal projects, farm subsidies, disarmament programs and violations of military law that enabled our enemies to capture the Pueblo and to sink our submarine Scorpion with, not only impunity, but also with dishonor to the integrity of this nation.

Read some of the opinions of our medical students and younger doctors in the various medical journals as they mimic the socialist philosophy to which they have been subjected from grade school through college. Then think again about John Dewey and his students who have been professors carrying on and perpetuating an evil philosophy all of these years.

One such professor from Teacher's College of Columbia University was George S. Counts who in 1950 wrote an article on how to combat communism. It advised this nation to become socialistic in order to fight the acme of socialism—communism!

Those of us who have not yet been brainwashed into the false concept that a wetnurse state is workable, and those of us who neither want nor expect to live off the labors of a dwindling number of workers, had better make their desires known before it is too late.

Tyrannical taxation by misrepresentation must be stopped by the intelligent electorate in concerted effective action.

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What About Medical Care Cost?

(One of a series prepared by Indiana Blue Shield)

"The competent, ethical physician is . . . guardian of the public interest in the area of consumer expenditure for medical care," Dr. Stephen J. Hoye, chairman of the Pawtucket (R.I.) Memorial Hospital medical staff executive committee, stated in the December 4, 1968, issue of the *Pawtucket Times*.

Dr. Hoye went on to say that it was necessary to differentiate costs over which the economists have control from the area which physicians control.

"The physician deals chiefly with specific services involved in individual cases," he said. "Is it necessary to hospitalize the patient? Do we need extensive x-ray and laboratory studies? How about private duty, special nursing care? What medications will do the job? . . . .

That a physician should be so quoted in the public press is not unusual these days. Today's consumers are concerned about the rising costs of health care.

On the other hand, the public today demands better quality health care than ever before. It's been easy for the public to assume that the physician is the one chiefly responsible for the spiraling costs of good health care. The M.D. is regarded as the "purchasing agent" since he's the one who directs the spending of the patient's dollars.

As the principal spokesman for American physicians, the American Medical Association and its officials have for some time now recognized the doctor's responsibilities in this area and cautioned doctors to hold the line where possible.

Last year, the then AMA president Dr. Milford O. Rouse said: "Efforts must be made by all segments of the health services industry, government, labor, and the public to moderate these costs that have risen because of inflation, increased demands for services, and the enactment of government health programs, which added hundreds of millions of dollars to the already overheated competition for health services. The AMA has urged individual physicians to do everything possible to help their patients get the most out of their health care dollar."

Spelling out the problem in even more detail last December before the House of Delegates, current AMA president Dr. Dwight L. Wilbur listed specific ways that physicians can put the rein on costs:

*Avoid hospitalizing any patient unless it is absolutely necessary.

*Reduce the length of stays in hospitals to the essential minimum.

*Instead, use extended-care facilities—nursing homes and home-care services—more often and participate in the expansion of all of them.

*Stimulate prepayment mechanisms on a voluntary basis and encourage all insurance carriers to provide comprehensive coverage for out-of-hospital services, both before and after hospitalization.

*Encourage patients and their families to carry this type of coverage; urge employers, labor unions and other groups to request that it be offered by their insurance carriers.

*Support the principle of income tax credits for health insurance.

*Keep charges on the basis of usual and customary fees with effective self-discipline and peer review to consider the size of the fee charged and the appropriateness of the service rendered.

*Encourage wider use of reliable, automated laboratory procedures, and pass the cost benefits on to patients.

Elaborating further, Dr. Wilbur stressed that the physician's "responsibility to moderate the total costs of the patient is imperative. Reactions to sharply rising costs will be severe and the medical profession as well as the hospital will be the visible targets of the frustrated and their representatives in government."

At the same time, the AMA president commended the National Association of Blue Shield Plans' action last fall in encouraging member Plans to make available comprehensive services and a program based on physicians' usual and customary fees.

Blue Shield's usual and customary program complies with the AMA's long-standing preferred method of payment for professional services.

Likewise, it meets the public's desire for predictable prepayment without regard to income limits.

Blue Shield's usual and customary program also recognizes the fact that in the free practice of medicine—some physicians do charge more than others. The purpose of such a program is to exert the least amount of influence possible upon the physician's individual charges. By definition, this program is geared to the usual charges of physicians, specialists, and general practitioners alike.

Cooperation between the medical profession and Blue Shield is essential in seeing that the public receives quality care at a reasonable price. ◄

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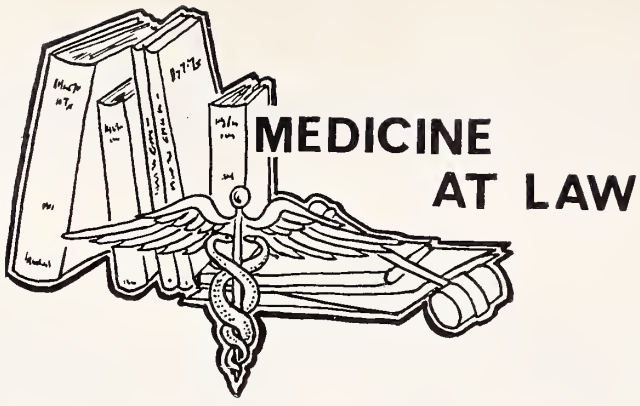
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One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

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Damage to Teeth During Anesthesia—A directed verdict for an anesthesiologist was set aside and a new trial ordered in a suit by a patient who broke one tooth and injured another while under anesthesia during an exploratory lumbar laminectomy. The evidence raised a question of fact as to whether the anesthesiologist was negligent in not examining the patient's mouth until after he was unconscious and in failing to observe the patient's capped tooth during that examination, a Tennessee appellate court ruled.

The anesthesiologist had not seen the patient before he was brought to the operating room. He did not examine the patient's mouth until after he administered sodium pentothal, which rendered the patient completely unconscious. While he was coming out of the anesthesia, the patient broke a capped tooth and injured another tooth on a plastic airway which the anesthesiologist had inserted in his throat.

The anesthesiologist's expert witness testified that it was routine and customary procedure for an anesthesiologist to examine a patient's mouth before an operation and to see that there were no dentures, bridgework, capped teeth, or other dental work which could be damaged or destroyed during the anesthesia; that he had had patients break teeth on two occasions, but in each instance he had examined the patient's mouth, noticed loose teeth, and warned the patient of the possible danger; and that it was the anesthesiologist's duty to examine a patient's mouth before administering anesthesia and to remove any bridgework, partial denture, or plate that the patient might have.

The anesthesiologist admitted that it was an anesthesiologist's usual and customary practice to examine the inside of a patient's mouth before inserting any tube or instrument therein. He testified that he would not have known that the tooth that broke off while the patient was coming out of the anesthesia was a capped tooth, even if he had examined the patient's mouth before administering the anesthesia.

The patient testified that the tooth which broke off had a porcelain front with a gold back. He contended that this should have been observed by the anesthesiologist if he had made a proper examination before administering the anesthesia.

Whether the anesthesiologist was negligent in not making an examination which would have disclosed the capped tooth's presence, so that he could have warned the patient of the danger of losing the tooth or taken steps to prevent its loss, was a question for the jury—*Hastings v. Hughes*, 438 S.W.2d 349 (Tenn., April 19, 1968; rehearing denied, Aug. 19, 1968; cert. denied by Supreme Court, Nov. 18, 1968).

Abolition of "Liability Rule" Advocated—A recent law review comment advocates abolishing the "locality rule" in medical malpractice suits in all states. The rule has already been abolished in some states.

Under the "locality rule" a physician cannot be held liable for malpractice if he can show that he has conformed to the standards of medical practice prevailing in his community or a similar one. The rule has a detrimental effect on a patient's chances of establishing a case against a physician, since the patient must prove the physician's negligence by the testimony of an expert witness who is familiar with the standards of practice in the community. It is frequently difficult, if not impossible, to get one physician to testify against another in a malpractice case, especially where the physicians practice in a small community.

The "locality rule" was adopted in 1880. The reason given for the rule was that a physician in a small rural community could not be held to the same standards of a practitioner in a metropolitan area, where there were greater opportunities to keep up with progress in medical science.

In view of the great developments in travel facilities and communications media and the large volume of medical literature that is readily available, the reason for the rule no longer exists. The rule should, therefore, be abolished, the author contends. Perpetuation of the rule is detrimental to society in that it enables physicians in small towns and rural areas to escape liability by the simple expedient of refusing to testify against one another. In the long run, the "locality rule" might also be detrimental to the medical profession. Permitting inept physicians who practice in areas having low standards of care to escape liability could well lead to a consequent lack of respect for the entire medical profession.—*The Locality Rule in Medical Malpractice Cases*, William John Stewart, 4 California Western Law Review 124 (1968).

No Liability for Adverse Drug Reaction—A patient who suffered a severe rash and extreme body swelling after taking Lincocin could not recover from the drug's manufacturer, a Missouri appellate court ruled. The evidence failed to show that the manufacturer knew or should have known that an adverse reaction such as the patient suffered would result from use of the drug.

A physician diagnosed the pain in the patient's ear as otitis media and indicated that she needed antibiotic treatment. When she told the physician that she had previously had allergic reactions to penicillin and streptomycin, he prescribed Lincocin.

About a week after she was started on the drug, the patient's body broke out and began to itch and swell. Before the condition was brought under control 95% of the patient's body was affected. She had to be hospitalized for a week.

The patient contended that the manufacturer was negligent in having failed to warn that an adverse reaction such as she suffered could result from use of the drug.

The package insert stated that the drug had been successfully administered to 460 persons having known allergies, including allergies to penicillin. The insert listed diarrhea, nausea, vomiting, abdominal cramps, skin rash, rectal irritation, vaginitis, urticaria, and itching as adverse reactions.

There was no evidence that anyone had ever experienced a reaction to the drug different in nature or more serious than those described in the insert. If such reaction had never occurred before, the manufacturer could not know about it and could not, in the exercise of reasonable care, have found out about it. In the absence of knowledge of such a reaction, there could be no duty to warn.—*Johnston v. The Upjohn Company*,—S.W.2d—(Mo., April 7, 1969).

Physician Liable for Overly Pessimistic Diagnosis—A patient who was alive 3½ years after a physician told him that he would die within 12 months was awarded damages of $40,000 by a California trial court jury in his suit against the physician. The patient testified that he had quit his job as the result of the diagnosis, thereby losing 18 years of seniority and pension rights.—News Release, Los Angeles, California, May 4, 1969.

$260,000 Awarded for Quadruplets' Death—The parents of quadruplets who died a day after they were born eight-weeks prematurely were awarded damages of $260,000 by a New York trial court jury in their suit against two physicians and a hospital.

The babies died a short time after nurses had, at the direction of the hospital's public relations staff, removed them from their incubators to pose for newspaper photographers. The parents charged that the physicians and the hospital had failed to provide adequate care for the babies.—News Release, New York. N.Y., April 27, 1969.

No Liability for Failure to Perform Spinal Surgery—A verdict for a neurosurgeon and an orthopedic surgeon was returned by a New York trial court jury in a patient's suit for allegedly negligent treatment of the paralysis from which he was suffering.

The patient broke his neck in a diving accident. Paralysis was immediate and total, below the level of a C5-C6 fracture with a ½ inch posterior dislocation.

The patient contended that the neurosurgeon and the orthopedist should have done a lumbar puncture, manometrics, and a myelogram and that those procedures should have been followed by a decompressive laminectomy for relief of spinal cord compression due to the dislocation. The patient contended that the paralysis would have been reversed in whole or in part if those steps had been taken. He presented evidence that the cord was found intact when the dura was opened during a laminectomy performed several months later.

The neurosurgeon and the orthopedist contended that the diagnostic procedures were unnecessary because the x-rays and clinical findings demonstrated an irreversibly crushed cord due to trauma. They contended that surgery was not indicated, would not have helped, and might have ruined whatever chance the patient had or killed him. They pointed out that there was no return of any neurological signs or function three hours after they performed a 50% reduction of the dislocation with the use of Barton tongs.

The patient presented expert testimony that surgery was indicated in a case such as this. The neurosurgeon and the orthopedist presented expert testimony that conservative treatment was indicated. The contention was made that the medical schools in the area taught that conservative treatment was proper in a case such as this.

The patient's cause of action against a consulting neurosurgeon who had advised against surgery was dismissed. He had no control over the treatment being rendered.

The trial court also dismissed the cause of action against the hospital for alleged negligence in failing to turn the patient. The hospital had been given no orders to turn him.—*Kayden v. Peninsula General Hospital*, Sup. Ct., Kings County. Docket No. 9348/1965 (N.Y., March 15, 1969). (Reference: Joel H. Lichenstein, Professional Insurance Company of New York, 90 Park Avenue, New York, N.Y. 10016).

Professional Partners Not Taxable as Separate Businesses—A city ordinance taxing "businesses" which provided that each person engaged in the practice of medicine.

Continued

law, or certain other enumerated professions should be deemed to be engaged in a separate business and taxable as such was unconstitutional, the Utah Supreme Court ruled.

The ordinance places a tax on businesses as a class. In order for the ordinance to be constitutional, all members of the class must be treated uniformly and equally. A medical partnership-business or law partnership-business is a single business. The city cannot convert such a single business into several independent businesses merely by declaring that each individual partner shall be deemed to be engaged in a separate business.—*Roe v. Salt Lake City*, 437 P.2d 195 (Utah, Jan. 23, 1968).

Druggist Not Liable for Miscarriage—A verdict was directed for a drugstore in a suit by a patient who suffered a miscarriage after taking a drug purchased from the drugstore.

The patient's physician prescribed Lutrexin for the purpose of relaxing her uterus. The drugstore gave her Lactonex which restores proper bacteria to the bowel. She took the drug for four days. Two weeks later she suffered a miscarriage.

The drugstore contended that there was no proof that the taking of the wrong drug caused the miscarriage.—*Sanders v. Marigold Drug Co.*, Cir. Ct., Cook Co., Docket No. 64L-5582 (Ill., April 8, 1969).

Physician Denied Fees Because of Bad Faith—A physician, a general practitioner, was not entitled to recover the fees charged a patient for treating her for a nervous condition, an Arizona appellate court ruled. The evidence authorized the finding that he had not acted in good faith toward the patient and that he therefore failed to establish the reasonable value of the services rendered.

The physician treated the patient for more than five years. At least 90% of the treatment was related to the patient's "tension," a condition for which, as the physician knew, she was also being treated by a psychiatrist. Although the patient was treated at the physician's office on an average of eight times a week, there was never any indication of any improvement in her condition. She paid the physician more than $4,000 over the period that he treated her. He claimed that more than $4,000 was still owing.

The physician-patient relationship is one of confidence and trust. A physician must use the utmost good faith in all his dealings with a patient.

The reviewing court said that, in light of the frequency of the visits, the nature of the illness that the physician attempted to treat, and the fact that he knew she was being treated for the same illness by a psychiatrist, the trial court was justified in holding that he had violated his duty of good faith in dealing with the patient, and therefore that he failed to sustain his burden of proof as to the reasonable value of the services rendered.—*Laubner v. Altick*, 454 P.2d 180 (Ariz., April 28, 1969).

Lack of Informed Consent not Established—A patient's suit for a physician's alleged failure to warn her of the risks of the proposed treatment, with the result that her consent to the treatment was not an informed one, was dismissed by a New York trial court. The patient failed to present any expert testimony as to the extent of disclosure that a reasonable physician would have made under the circumstances. Thus, the evidence did not raise an issue for the jury.

The gist of the "informed consent" theory of liability is that a physician has a duty in certain circumstances to inform his patient of the known risks of the proposed treatment so that the patient will be in a position to make an intelligent decision as to whether to submit to the treatment.

In an "informed consent" case, the patient must establish affirmatively by expert medical testimony the community standard with respect to disclosure of the risks of the proposed treatment and that the physician has not complied with that standard. The patient here failed to present any such expert testimony. She thus failed to make a prima facie case, and her suit had to be dismissed.—*Petterson v. Lynch*, 229 N.Y.S.2d 244 (N.Y., April 17, 1969).

Settlement in Suit for Chloromycetin Death—A settlement of $75,000 was agreed on in a suit against a physician and a drug manufacturer for the death of a patient from aplastic anemia which developed after the physician prescribed chloromycetin for her.

The physician was charged with negligence in prescribing chloromycetin when other drugs were available which would have been equally effective in treating the upper respiratory condition from which the patient was suffering. The physician was also charged with negligence in not making blood studies to determine if the drug had caused any blood dyscrasias.

The manufacturer was charged with negligence in not giving adequate warnings of the drug's side effects in its advertising and in failing to instruct its detailmen to inform physicians of reported cases of aplastic anemia following use of the drug.—*Pierson v. Parke-Davis & Company*, (N.J., May 13, 1969). (Reference: Herbert E. Greenstone, Esq., Greenstone & Greenstone, Broad St., Newark, N.J., 07102). ◄

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ABSTRACTS, BOOK REVIEWS

PROGRESS IN CLINICAL RHEUMATOLOGY

Edited by Allan St. J. Dixon, M.D., Little, Brown & Co., Boston, Mass., 1965; 371 pages with numerous illustrations.

An even two dozen distinguished rheumatologists, all but five from England, have done their very best to illumine the very many, still grey regions in this area of medicine. Their very considerable success makes this volume very much worthwhile.

The readability of almost all the chapters is very high, indeed. For myself, I would pick as an example the discussion on "Reiter's Syndrome." Drs. Hancock and Mason have examined in depth a disease that baffles the best of us. In a mere score of pages (including FOUR pages of bibliography), they make this condition almost clear! I can only say, "Amen", to their conclusion that the syndrome results not as a direct response to an infection but is "an abnormal reaction pattern, perhaps determined genetically."

Similarly, the non-specialist can derive much profit from reading such chapters as those on rheumatoid arthritis, gout, amyloidosis, etc. The very last chapter #23 by the editor, Dr. Dixon, is a veritable tour de force. "The Rarer Rheumatic Diseases" are listed practically by title with a crisp paragraph presenting each item's salient features. I know no other spot where one can obtain more information with less effort!

Of course, the binding and printing are good; typographical errors are too trifling for comment. The busy practitioner can do worse than have this volume available for scanning this or that chapter in that 15 minute gap between engagements!

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

THE ROLE OF LEARNING IN PSYCHOTHERAPY

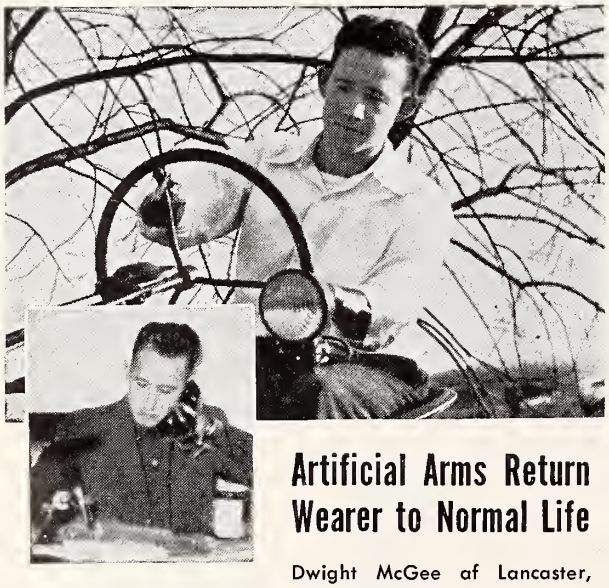
Ciba Foundation Symposium, edited by Ruth Porter, Little, Brown & Co., Boston, Mass., 1968; 340 pages; $12.00.

Maybe, I'm showing my advancing years; maybe, I'm a mite schizophrenic about my colleagues in psychiatry and psychology. How did they manage to get all this mileage rehashing the aging question of "should we treat the patient's symptoms or should we give him some insight into the unconscious (id) motivations causing the self-same symptoms?"

I admit that I'm very proud of a Moscow newspaper photo (circa 1935) showing me standing by Pavlov (Ivan Petrovich, no less) while attending an International Physiological Congress. I've listened to discourses by Freud. However, time does march on—ineluctably. Psychopharmacology is here; it is 50 years since the debate began to heat up. Let's get on with the last third of the 20th (NOT 19th) century.

So: As a historical bit of folklore—I'm all for this symposium; as something of teaching, contemporary value? How naive do they expect the doctors of today to be?

ARNOLD LIEBERMAN, M.D.
New York, N.Y.



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Abstracts From Various Literature, Prepared by AMA

MOBILE EMERGENCY UNIT SAVES LIVES IN HOSPITAL-LESS COMMUNITY

Q. L. Wood (Rancho Santa Fe, Calif.)
Hospitals 43:59-61, (March 16), 1969.

A semirural community, too small to have its own hospital, needed better on-the-scene emergency care. The community designed and put into service a specially equipped ambulance—essentially a low-cost mobile hospital emergency room which is maintained and operated by the fire department. Local doctors are skilled in the use of the equipment. The driver and the attendant are firemen skilled in heart-lung resuscitation, use of the cardioscope, the electrocardiograph and the defibrillator.

HYPOPROTHROMBINEMIC BLEEDING IN YOUNG INFANT

M. H. Moss (200 Engle St., Englewood, N.J.)
Amer. J. Dis. Child. 117:540-542, (May), 1969.

A seven-week-old infant developed hypoprothrombinemia and bleeding while receiving a soy protein isolate formula. She had received antibiotics orally. Bleeding ceased and the prolonged prothrombin time was promptly corrected after administration of intramuscular vitamin K. Contrary to previous reports, some soy formulas may be low in vitamin K content. Vitamin K

supplementation is recommended for infants fed formulas which are low in vitamin K, particularly when diarrhea is present or antibiotics are being given.

HUMAN CRYSTALLINE INSULIN FROM NONDIABETIC AND DIABETIC PATIENTS

K. Brunfeldt, T. Deckert, and J. Thomsen (Steno Memorial Hospital, Copenhagen)

Acta Endocrinologica 60:543-549, (March), 1969.

Crystalline insulin was prepared from pooled pancreases from deceased maturity-onset diabetics and nondiabetics. The amino acid composition, immunological reactivity, and hypoglycemia activity were compared. There were no differences between the two preparations.

FARMER'S LUNG

W. P. Warren, M. A. J. Mandl, and B. Rose (Royal Victoria Hospital, Montreal)

Canad. Med. Assoc. J. 100:699-704, (April 19), 1969.

Four patients with clinical histories compatible with farmer's lung were found to have circulating precipitating antibodies to specific purified fungal extracts by double diffusion in agar. When two of these patients were skin tested with appropriate fungal antigen, the positive four hour skin reactions were biopsied. By light and immunofluorescent microscopy, these reactions were compatible with Arthus reactions. The pulmonary function tests revealed predominantly a restrictive type of disease. Therapy is directed toward the utilization of simple face masks, avoidance of antigen, and the use of corticosteroids to suppress the inflammatory response.

CURRENT CLINICAL RESULTS OF RENAL TRANSPLANTATION

T. L. Marchioro (University of Washington School of Medicine, Seattle)

Arch. Intern. Med. 123:485-490, (May), 1969.

Overall data on 1,741 kidney transplants reported to the Human Kidney Transplant Registry to Jan. 1, 1968, reveal that in the most recent two-year period, 78% of sibling grafts are functioning at one year and 76% are still functioning at two years. One- and two-year survival figures for cadaveric grafts performed during the same time interval are 45% and 38% respectively. Individual centers have achieved overall results which exceed those reported by the registry. Patient survival exceeds graft survival in many institutions by virtue of the availability of interim hemodialysis and the demonstrated practicability of regrafting. One of the most important problems is the possible development of malignancy in patients receiving long-term immunosuppression.

RECURRENCE OF GLOMERULONEPHRITIS IN TRANSPLANTED KIDNEY

F. J. Dixon (476 Prospect St., La Jolla, Calif.), J. J. McPhaul Jr., and R. Lerner

Arch. Intern. Med. 123:554-557, (May), 1969.

The mechanism of injury operative in kidneys affected by glomerulonephritis may be inferred from the pattern of immunoglobulin deposits detected by immunofluorescent examination of such organs and antibodies eluted from them. Studies of tissue from native, glomerulonephritic human kidneys, kidney allografts in such patients, or usually both, indicate that glomerular disease in the allograft is mediated by a mechanism similar to that operative in the native kidney. Moreover, the frequency of clinical and histological disease in allograft patients who had discernible immunoglobulin deposits on their native diseased kidneys suggests a continuation of original disease now afflicting the allograft.

SURGICAL TREATMENT OF THYROID CARCINOMA

J. A. Buckwalter (Department of Surgery, University Hospital, Iowa City)

Arch. Surg. 98:579-585, (May), 1969.

The following recommendations emerged from a study of 322 microscopically confirmed cases of thyroid cancer followed for as long as 40 years. Treatment of well-differentiated lesions is lobectomy or total thyroidectomy with neck dissection when the regional lymph nodes are involved. Radioactive iodine should be tried when there is residual neoplasm; if ineffective, external irradiation is indicated. All patients should be given dessicated thyroid. As much of the poorly differentiated lesion should be excised as can be done without producing hypoparathyroidism or dividing both recurrent laryngeal nerves. Residual neoplasm is treated by external irradiation.

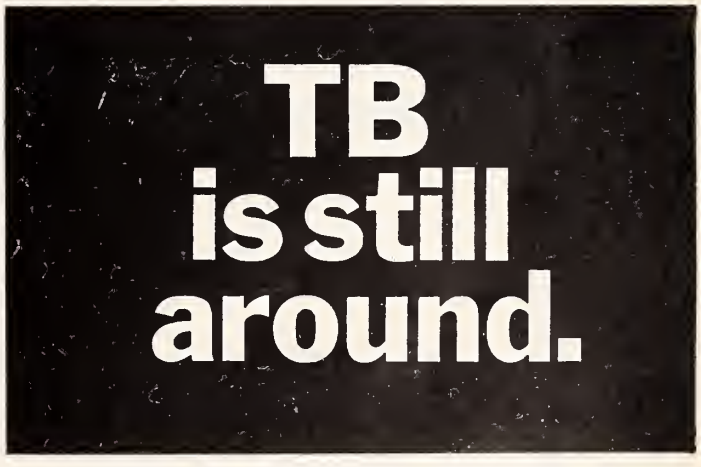
CARDIAC TRANSPLANTATION AS PALLIATION OF ADVANCED HEART DISEASE

D. A. Cooley et al. (1200 Moursund Ave., Houston)

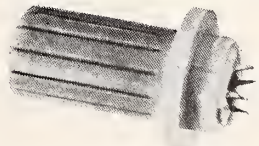
Arch. Surg. 98:619-625, (May), 1969.

Fourteen patients with irreversible heart disease in terminal heart failure received cardiac allografts. The etiology was atherosclerosis in 12, rheumatic multivalvular disease in one, and endocardial fibroelastosis in one. A two-month-old infant had total cardiopulmonary transplantation for a complicated atrioventricular canal with intractable heart failure and pulmonary edema

Continued



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Continued

but died on the first day after operation. An attempted xenograft with a sheep's heart was unsuccessful and the patient died of hyperacute rejection. Seven patients were still alive up to six months postoperatively. The remaining seven deaths were caused by pneumonia (one patient), intestinal gangrene (one), rejection (three), and sepsis (two). Azathioprine steroids and antilymphocytic globulin were used for immunosuppression. Tissue typing for histocompatibility was performed in each but no patient had better than a C match (Terasaki). Operation was performed at normothermia using a bubble diffusion oxygenator and the allograft was neither perfused nor cooled during transfer from donor to recipient.

BIOLOGIC COST OF SMOKING

F. R. Lemon (University of Kentucky School of Medicine, Lexington) and J. W. Kuzma

Arch. Environ. Health 18:950-955, (June), 1969.

The mortality and survival of 34,217 Seventh-Day Adventists (SDAs) from 1960 to 1962 have been subjected to a life-table analysis and compared to similar data for the simultaneous California population. The preferential survival experience and life expectancy of the SDAs are of a high order, considering the ages (35 years and above) to which the analysis was limited. The life expectancy advantage of SDAs at age 35 and over exceed present California life expectancies by an amount greater than that gained in the US population during the past 40 or more years. On the basis of prior detailed studies of the mortality experience of SDAs the authors postulate that the great preponderance of this preferential life expectance is due to the SDA practice of abstinence from the use of tobacco. One of the biological costs of cigarette smoking is a substantial reduction in life expectancy.

TRAUMATIC RUPTURE OF THORACIC AORTA

N. R. Thomford, W. G. Pace, and C. V. Meckstroth (Ohio State University College of Medicine, Columbus)

Amer. Surg. 35:244-249, (April), 1969.

In a series of patients with traumatic injuries of the aorta, eight had traumatic laceration of the thoracic portion of the descending aorta, caused by severe blunt trauma sustained in an automobile accident. With few exceptions, the laceration occurs immediately distal to the origin of the left subclavian artery. Widening of the mediastinum from hematoma is a common roentgenologic finding. Repair of aortic lacerations in patients who survive to reach a hospital is technically feasible, but delay in diagnosis or operation often results in death.

TUBE FEEDING SYNDROME IN HEAD AND NECK SURGERY

J. W. Walike (Department of Otolaryngology, University of Washington, Seattle)

Arch. Otolaryng. 89:533-536, (March), 1969.

The tube feeding syndrome consists of dehydration, hypernatremia, hyperchloremia, and azotemia. It arises from feeding a patient excessively high solute loads or not providing sufficient additional water to utilize usual tube feeding diets. It is most apt to occur in elderly patients with compromised renal function. Tube feeding diets containing more than 70 gm/liter of protein should be given with care. This syndrome developed in a 70-year-old male who underwent a total laryngectomy and radical neck dissection. ◄

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Date Nov. 30-Dec. 3
Place Denver, Colo.

NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville

INDIANA ROENTGEN SOCIETY, INC.
Date March 1, 1970
Place Holiday Inn East, Indianapolis

INDIANA ACADEMY OF GENERAL PRACTICE
Date April 14-16, 1970
Place Indianapolis

INDIANA DENTAL ASSOCIATION
Date May 13-16, 1970
Place Indianapolis Hilton Hotel, Indianapolis

INDIANA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS
Date May 6-7, 1970
Place Stouffer's Inn, Indianapolis

BONE AND JOINT CLUB
Date October 22, 1969
Place The Athenaeum, Indianapolis

INDIANA SOCIETY OF ANESTHESIOLOGISTS
Date May 23, 1970
Place Marott Hotel, Indianapolis

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date May 6-8, 1970
Place Morris Inn, South Bend

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 13-16, 1969
Place Indianapolis

INDIANA PUBLIC HEALTH ASSN., INC. & INDIANA TUBERCULOSIS ASSN. JOINT MEETING
Date April 21-23, 1970
Place Stouffer's Indianapolis Inn

AMERICAN COLLEGE OF SURGEONS, INDIANA CHAPTER
Date April 16-18, 1970
Place Indiana State University, Terre Haute

INDIANA ASSOCIATION OF PATHOLOGISTS
Date December 6, 1969
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MONTHLY REPORT—August, 1969

Disease	Aug. 1969	July 1969	June 1969	Aug. 1968	Aug. 1967
Animal Bites	1221	1408	1153	1177	1091
Chickenpox	41	105	247	50	24
Conjunctivitis	122	150	121	94	47
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	21	25	9	50	22
Gonorrhea	685	707	566	640	428
Impetigo	189	212	58	211	96
Infectious Hepatitis	21	32	41	49	32
Infectious Mononucleosis	20	33	49	31	8
Influenza	272	237	368	191	32
Measles					
Rubeola	1	14	15	40	7
Rubella	38	75	193	58	25
Meningitis, Meningococcal	2	1	6	3	0
Meningitis, Other	4	3	2	5	3
Mumps	93	99	236	78	142
Pertussis (whooping cough)	3	9	5	28	36
Pneumonia	137	173	146	90	92
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	328	416	386	438	250
Syphilis					
Primary & Secondary	27	33	34	35	16
All Other Syphilis	81	117	131	145	66
Tinea Capitis	6	8	2	6	0
Tuberculosis (Active)	82	81	97	61	63

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a consistent buffering anticostive† antacid

†Avoids constipation.

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Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

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Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

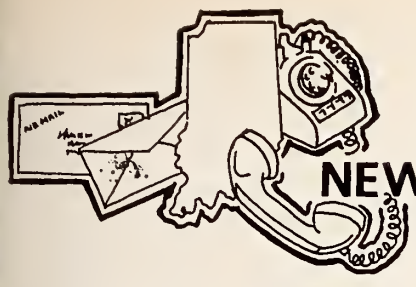
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NEWS NOTES

Governor Makes Appointments To Medical Education Commission

Gov. Edgar D. Whitcomb has announced the appointment of 23 members to the new Indiana Commission on Medical Education.

Physician appointees to the board are: **Drs. Patrick J. V. Corcoran, Evansville; Joseph Black, Seymour; W. D. Snively, Evansville; Norman Wilson, Crown Point; Glenn W. Irwin, Indianapolis; Walter A. Compton, Evansville; Franklin A. Bryan, Fort Wayne; Fletcher McDowell, Muncie and James Easter, New Castle.**

John Twyman, director of the Lake County Medical Society, also was named to the commission.

Re-Elected to AAGP

Three more Indiana physicians have been re-elected to active membership in the American Academy of General Practice. They are: **Drs. Edward L. Hollenberg, Winamac; George G. Morrison, Jr., Lawrenceburg and Roland Weitzel, Princeton.**

Dr. Glock Named

Dr. Maurice E. Glock, Fort Wayne, has been appointed to represent the Indiana State Medical Association on the Medicaid Advisory Committee. Other appointees to the committee are: **Drs. George F. Parker, Indianapolis; and Robert E. Snodgrass, Indianapolis.**

News from Indiana Chapter, American College of Surgeons

The Indiana Chapter of the American College of Surgeons in conjunction with the Fort Wayne Academy of Medicine and Surgery and the Mad Anthonys sponsored a Symposium on Athletic Injuries on August 12 at the R. Nelson Snider High School in Fort Wayne. More than 175 persons registered for the event.

Discussion leaders included **Dr. Les Bodner,** team physician for Notre Dame; **Dr. Robert Murphy,** recognized authority on heat exhaustion from Ohio State; **Dr. Brad Bomba,** team physician from Indiana University; Mr. Pinky Newell, trainer at Purdue University and Mr. Mel Blinckenstaff, trainer at Indiana State University. Mr. Bill Orwig, Athletic Director at Indiana University was the moderator.

Audience reaction prompted a plan to repeat the symposium at Fort Wayne on an annual basis, and possibly organize similar meetings in three or four other locations in the state.

Dr. Slaughter Aids Others

Dr. John C. Slaughter, Evansville, recently made his eighth trip to Central America for his Holiday for Humanity. Dr. Slaughter attended 78 meetings in 33 days in six Central American countries, in addition to delivering packages of medicine to clinics. Dr. Slaughter is founder of the Holiday for Humanity organization, which asks medical people to give a month's vacation to help the impoverished of Latin America.

Campus View

by Caroline Yeager

Senior Class President Theron Ebel reports that 24 seniors are participating in the new freshman counseling program this year. Supplementing the faculty counseling program, the seniors met with their assigned freshmen during orientation week to offer guidance and to obtain a faculty counselor for students requesting one. The seniors will continue to assist their freshman group throughout their freshman year.

Work has begun on the annual Senior Day activities. John Brown and Darrel Regier, seniors, are co-chairmen for the March 1, 1970, day of fun, food, and NIMP results.

Larry Ley, junior, obtained four of his classmates to present papers on their research at the ISMA Convention in October here in Indianapolis. Robert Cates discussed "Proteolysis of Thyroglobulin"; Glenn Bingle presented "Electron Microscopic Studies of Myelination." "Method of Routine Examination of the Cardiac Conduction System and Cases of Forensic Interest" was the topic planned by Robert Wrenn. Robert Forste discussed the "Enzymatic Basis for Cancer Chemotherapy."

Robert Williamson, junior, has been appointed to his second year on the IUMC Curriculum Evaluation Committee.

Congratulations to past SAMA President Robert Forste on his August 16 marriage to Ann Nesbitt of Kokomo.

The Phi Chi summer outing on Saturday, August 23, at the Northern Beach Club was a success, according to Charlie Zeller, junior, who helped organize the affair. Phi Chi men treated wives and dates to softball, games, food, and Phi Chi brew as a reward for a summer of classes finished and a break before more night call in the fall. Steve Spurgeon, senior, is the new Phi Chi president.

The freshman and sophomore classes were busy this fall with orientation. On Tuesday, September 2, they met to take care of the perennial paperwork required by the university. Wednesday morning featured a three-hour program about the extracurricular activities for medical students. Don Dian, junior, discussed SAMA activities in general and Joe Ramsdell, junior, talked about opportunities for underclassmen at the South Side Community Health Clinic. Each of the professional fraternities presented talks on what they had to offer the men students. In addition, a film prepared by Channel 4 of Bloomington on the South Side Community Health Clinic was shown. On Wednesday afternoon, a panel discussion on trends in today's medicine was presented by members of the faculty, staff and upperclasses. The panel was

Continued

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moderated by Dr. Jack Hickman, Assistant Dean for Student Affairs.

On Thursday, September 4, at 7:00 p.m., SAMA's pet project, the Community Health Clinic, sponsored an open house at 234 West Morris Street to meet and greet incoming freshmen and those who wished to become more familiar with the services offered by the clinic.

Dr. Carroll Gives Tips

Dr. Mary D. Carroll, Crown Point, talked on the rules to follow while dieting before a recent meeting of the Gary Lights, a branch of the TOPS Club.

Dr. Boren Honored

Dr. Paul R. Boren, Poseyville, was named Man of the Year recently by the Poseyville Chamber of Commerce. Dr. Boren was chosen on the basis of his community achievement in 1968.

Legion Anniversary

The Members of Vincennes American Legion Post No. 73 gathered recently to celebrate their 50th anniversary as a club. On hand to help in the celebration was **Dr. M. L. Curtner,** the post's first commander.

Air Pollution Speaker

Dr. John B. Nicosia, East Chicago, spoke on air pollution recently before a national air pollution conference in Washington, D.C.

Diabetes Group Meeting

The Lay Society of the Indianapolis Diabetes Association met recently to hear **Dr. Richard C. Powell,** president of the association, speak on "New Horizons in Diabetes."

Dr. Yoder Speaker

Dr. Carl Yoder, Middlebury, was guest speaker recently to the young people at Pleasant Oaks Mennonite Church. The film "Bennies and Goof-Balls" was also shown.

Dr. Kesim Addresses Group

Dr. M. H. Kesim, Elkhart, discussed cystic fibrosis recently before a meeting of the Mothers of Twins Club in Elkhart. A film on the disease also was shown.

Dr. Egger Speaker for Programs

Dr. Ross L. Egger, Daleville, has spoken at a number of programs in the last few months. June 4 he was a consultant concerning the use of computer terminals in small outlying hospitals at the Kansas Regional Medical Program in Kansas City. June 21 he participated on a panel discussing postgraduate education at the University of Oregon Medical School at Portland. July 29th he was a consultant concerning the establishment of Family Practice Training Programs in Lake County with the Lake County Family Physicians at Gary and he traveled to the Ohio Regional Medical Program at Columbus August 5 as a consultant concerning the use of computer-assisted instruction in postgraduate education.

John Shaw Billings History of Medicine Society November Meetings

The John Shaw Billings History of Medicine Society has initiated two separate programs for the 1969-70 school year at the I.U. Medical Center.

The medical school has provided time for a series of distinguished lecturers to the medical students during the year; and for those members of the society who can only meet in the evening, a program has been provided which is separate and distinct from that of the medical students.

The student lectures are held on Dean's Hours (4:00 to 5:00 p.m.) Speaker at the November 5 meeting will be Dr. Lester S. King, senior editor of *The Journal of the American Medical Association.* His topic will be "Development of Scientific Medicine."

The regular monthly dinner meetings of the society, as well as the student lectures, began in September.

Speaker at the November 12 dinner meeting will be Dr. Gareth Gilkey who will speak on "Vietnam." Each monthly dinner meeting is preceded by a social hour and dinner on the mezzanine of the Student Union Building, I.U. Medical Center, Indianapolis, beginning at 6:30 p.m.

President of the society again this year is Dr. William M. Loehr. The new program chairman who has arranged the series of both meetings is Dr. Hanus J. Grosz, Professor of Psychiatry at the medical school.

Dr. Gootee on TV

Dr. Thomas Gootee, Jasper, was interviewed by students from St. Benedict College recently on "Meet the Students," a local Jasper TV show. The students interviewed Dr. Gootee on "Medical Practices Today."

Speaks to RN Club

Dr. Stanton Cope, Huntington, showed films on his vacation in Acapulco recently before a meeting of the Huntington RN Club.

Dr. Rendel Named

Dr. H. E. Rendel, Mexico, has been named a member of the Miami County Hospital Association which will be responsible for construction of a new 40-bed wing to Dukes Memorial Hospital, Peru.

Anderson College Speaker

Dr. Jerry L. Stevenson, chairman of the biology department at Anderson College, spoke on "Cancer—What is It" and "Causes and Cures" as part of a series of eight popular science lectures recently at the college.

Computerized System for Processing Medical Histories

Preventicare Systems, Inc., of Ann Arbor, Michigan, announces the development of a computerized system for the processing of the history and physical examination components of a medical history.

Patient-oriented medical history cards are filled out by the patient. When processed in the computer, the resulting written history appears in medical terminology. The physician is provided with a deck of physical examination cards which he fills in as he does the examination. The deck of completed cards is then processed. Time involved is less than five minutes processing time.

Cost of history and physical examination record is approxi-

mately $3. The same operation costs, on the average in U. S. hospitals, about $20.

Attends Seminar

Dr. Lester Renbarger, Marion, Grant County Health Officer, was co-chairman of arrangements at a recent postgraduate seminar for city and county health officers in Indianapolis.

Dr. Kinzer is Speaker

Dr. Leroy D. Kinzer, Markle, spoke recently at a Missionary Conference for the United Methodist Churches of Huntington. Dr. Kinzer participated in a lay missions program in the Congo in 1968.

Physician Participants

Dr. John Moenning, Greenfield, and Drs. Neil Strickland and Herschel Moss, Indianapolis, participated in a panel discussion on several topics recently on the Vivian Show, a feature of Radio Station WSMJ at Greenfield.

Visit Vietnam

Dr. Paul Waitt, Sheridan and Dr. Donald Kerner, Indianapolis, each spent two months in Vietnam earlier this year, serving the civilian population with the American Medical Association's volunteer physicians. This was Dr. Kerner's second 60-day tour of duty.

New Medicredit Corporation Offers New National Health System

Dr. F. J. L. Blasingame, former executive vice president of the AMA, is a member of the board of directors of Medicredit, a private corporation offering a new national health system.

It will provide service to both patient and physicians with a convenient means of payment, a low cost hospital insurance plan and a computerized personal medical history service.

Its personal medical history data files will be computerized and will be available in moments to any physician or hospital in the country in the event of an accident or emergency situation.

"Woman of the Year"

Dr. Lillian Holdeman, South Bend, has been chosen "Woman of the Year" by the Women's Bureau of the South Bend-Mishawaka Area Chamber of Commerce. Dr. Holdeman is health coordinator of the South Bend Community School Corporation, working on the school system's health programs; a charter member of the Altrusa Club and a board member of the Tuberculosis League.

Dr. Bowen is Speaker

Dr. Otis R. Bowen, Bremen, speaker of the Indiana House of Representatives, addressed the Kokomo Rotary Club recently on the 1969 session of the General Assembly.

Dr. Wilson Appointed

Dr. Norman J. Wilson, Crown Point, medical director of Parramore Hospital since 1965, has become director of medical education at Gary Methodist Hospital. His new duties will place him in charge of instruction in all hospital techniques as practiced by the staff.

Symposium Moderator

A symposium on the current concepts in antibiotic therapy was held recently in the Center for Continuing Education on the campus of the University of Notre Dame. **Dr. Robert L. Devetski,** director of residency training at St. Joseph's Hospital, served as moderator. **Dr. Jene Bennett,** associate director of the South Bend Medical Foundation, spoke about the methods currently available to the clinician for determining the sensitivity of an organism to any given antibiotic.

Physician Selected

Dr. Eugene P. Gregoline, Gary, has been appointed medical advisor for the Indiana State Selective Service Commission.

Becomes Fellow

Dr. Robert F. Rourke, Terre Haute, has been installed as a Fellow of the American College of Obstetricians and Gynecologists.

Dr. Blackburn Speaks

Dr. Howard Blackburn, Noblesville, spoke recently at a meeting of the Progress Club at Sheridan. Dr. Blackburn, president of the Indiana Museum of Transportation and Communications, discussed the museum which collects and preserves all types of transportation equipment of this country and particularly Indiana.

Dow Chemical Company Produces 52 Million Doses of Measles Vaccine

The Dow Chemical Company Rx Pharmaceuticals (formerly Pitman-Moore) announce proudly that the Zionsville laboratories have now produced more than 52 million doses of Lirugen, the one-shot measles vaccine. The vaccine has progressed to world-wide use and has almost wiped out measles in this country.

The United States has had only some 200,000 cases in 1969 as compared to the pre-vaccine score of over five million. Lirugen has been administered extensively by private physicians. Community-wide public health clinics, of which there have been about 3,000 nationwide, have provided for the indigent and low income group.

Speakers on Program

Drs. Otis R. Bowen, Bremen and Tom Shields, Richmond, spoke at the Union-Wayne County Lincoln Day Banquet on the Earlham College campus earlier this year.

Dr. Erhart on TV

Dr. H. O. Erhart, Ferdinand, was interviewed by students from St. Benedict College recently on "Meet the Students," a local Jasper TV show. The students interviewed Dr. Erhart on the subject of "Gun Control and Hunting." Dr. Erhart is a gun enthusiast and big-game hunter.

Dr. Frazier Appointed

Dr. J. L. Frazier, Kokomo, has been appointed medical director of the United Presidential Life Insurance Company of Kokomo. He is presently president of the Howard County Medical Society and is an active staff member of the Howard Community and St. Joseph's Hospitals.

New Publications Available on Portable Fire Extinguishers

Portable fire extinguishers, their installation, uses and maintenance are discussed by the National Fire Protection Association in recent publications.

NFPA No. 10 is a 44-page booklet on standard for installation

Continued

NEWS NOTES

Continued

which sells for $1.00. NFPA No. 10A is another 44-pager which discusses recommended good practice for maintenance and use—price $1.00. Address is 60 Batterymarch St., Boston 02110.

Physician on Panel

Dr. Edgar C. Stuntz, Lafayette, participated recently on a panel on Women and Alcoholism at St. Joseph's College, Rensselaer. Co-sponsors of the program were the St. Joseph's Student Association and College Lecture Series.

Elected President

Dr. William A. Kleifgen, Fort Wayne, has been elected president of the Fortnightly Club for the 1969-70 season.

Dr. Mitchell Speaks

Dr. John B. Mitchell, Evansville, spoke on "PKU Developments" at a recent meeting of the Southwest Indiana District Diabetic Association. Dr. Mitchell is associate director of medical research for the association.

Addresses Group

Dr. James S. Reynolds, Gary urologist, addressed the Calumet Industrial Nurses Association recently at Highland. His subject was "Renal Injuries and Diseases."

Wm. S. Merrell Company Announces New Medical Legal Film

The Wm. S. Merrell Company announces the availability of their new medical-legal motion picture film "Next Witness."

It is a 24-minute, 16mm. color presentation on medical testimony and covers both preparation and presentation in a court of law. It may be obtained on free loan by writing Film Library, Wm. S. Merrell Company, 1269 Gest St., Cincinnati 45203.

Dr. Lloyd Honored

Dr. Frank P. Lloyd, director of medical research at Methodist Hospital, Indianapolis, has been named a recipient of the Brotherhood Award of the Indianapolis branch of the National Conference of Christians and Jews. The award is given each year for "civic contributions in the cause of brotherhood."

Speaks for Group

Dr. Carl Porter, Jasonville, discussed the problems of senior citizens at a recent meeting of the Wednesday Research Club of Jasonville.

Series Speaker

Dr. Irving Rosenbaum, Indianapolis pediatrician, addressed the second session in a kindergarten-parent education discussion series of the Jewish Educational Association recently at Indianapolis.

Dr. Covey Speaks

Dr. Thomas Covey, Valparaiso pediatrician, participated in a panel discussion at a meeting of the Northview School Parent Teachers Association there recently. An optometrist and pedodontist participated on the panel with Dr. Covey. ◄

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FUTURE MEETINGS, SEMINARS, COURSES

Fort Wayne Medical Society Postgraduate Courses Listed

The Committee on Postgraduate Medical Education of the Fort Wayne Medical Society has announced topics for the 1969-70 society program.

Dates, topics and speakers are as follows:

Nov. 4, 1969—"Muscular Rheumatism," Alan MacKenzie, M.D.

Dec. 2, 1969—I.A.G.P. 17th Annual Road Show.

Jan. 6, 1970—Third Regional Heart Symposium.

Feb. 3, 1970—Mental Disease (speaker to be announced).

Mar. 3, 1970—"Neonatology," Billy Franklin Andrews, M.D.

Apr. 7, 1970—"Current Status of Nuclear Medicine," D. Bruce Sodee, M.D.

May 5, 1970—"The Humorous Side of Medical Practice," Russell B. Roth, M.D.

Diabetes Association of Greater Chicago Symposium

The Diabetes Association of Greater Chicago will conduct its Twelfth Annual Symposium on Diabetes at the University of Chicago Center for Continuing Education, 1307 E. 60th St., Chicago 60637, on Friday, November 21, 1969. The registration will begin at 8:30 A.M.

The symposium will be devoted to "Clinical Applications of Newer Knowledge in Diabetes." The morning program will open with a discussion on "Diabetic Retinopathy," from both the investigative and the clinical point of view, presented by David G. Cogan, M.D., Boston; David Shoch, M.D., Chicago; and Arthur R. Colwell, Sr., M.D., Chicago.

Faculty members, from the various medical institutions in Chicago, will then hold a series of workshops, with smaller groups of the attending audience dealing with special problems in diabetes. These group discussions will continue into the luncheon period.

The afternoon will be devoted to the presentation of the Thirteenth Woodyatt Memorial Lecture by Randall G. Sprague, M.D., Rochester. Dr. Sprague will review the development and impact of investigative knowledge on clinical application to diabetes mellitus. Dr. Arthur R. Colwell, Sr., will introduce the Woodyatt Memorial Lecturer.

Registration is free for members of the Diabetes Association of Greater Chicago or the American Diabetes Association and for medical students and resident house staff members and dietitians. The fee for non-members is $10.00. Inquiries can be addressed to: Diabetes Association of Greater Chicago, 620 N. Michigan Ave., Chicago, Ill. 60611.

Cleveland Clinic Foundation Announces Postgraduate Courses

The Cleveland Clinic Educational Foundation will conduct three postgraduate courses during the month of November.

The first courses will be on "Perspectives in Lipids and Lipoproteins" on November 6 and 7; the second will be "Diseases of the Small Intestine and Colon on November 12 and 13 and the third course will be entitled "Neurosurgical Technics" on November 19 and 20.

The registration fee is $50; half this amount will be charged interns and residents. The address is 2020 E. 93rd St., Cleveland 44106.

American Fracture Association Meeting Will be November 9-13

The American Fracture Association meets in Columbus, Ohio, at the Sheraton-Columbus Motor Hotel, on November 9 to 13.

One special feature will be an x-ray film conference for one hour each morning for discussion of problem films submitted by members and guests.

Hoosiers Dr. Virgil McCarty of Princeton and Dr. Leo K. Cooper of Gary will moderate this presentation. Dr. F. Robert Brueckmann of Indianapolis and Dr. Cooper will read papers. Drs. Irvin Scott of Sullivan and Harry E. Mock, Franklin and Drs. McCarty and Cooper are members of the Board of Governors.

"Delivery of Medical Care In the 70's" Topic of Meeting

The Institute of Medicine of Chicago is presenting a two-day workshop program on "Delivery of Medical Care in the 1970's," at the Ambassador Hotel, on November 21 and 22. Registration fee for non-members is $50.

Indiana Thoracic Society Announces Winter Conference

A Winter Conference for physicians will be sponsored by the Indiana Thoracic Society. This conference will be a two-day session beginning Friday evening, December 5, and concluding Saturday afternoon, December 6. All sessions will be held at the Atkinson Hotel, Indianapolis.

The Friday evening session will be devoted to the presentation of interesting cases including:

1. Improvement of Ventilation With Resection of Pulmonary Cyst.
2. Respiratory Failure—Treatment (with recovery).
3. Long Term Antibiotic Therapy in Chronic Respiratory Disease.

The Saturday scientific session will consist of four topics:

1. Problems in Setting Up a Respiratory Disease Care Unit in a Local Hospital.
2. Pulmonary Embolism.
3. Surgical Diagnostic Procedure-Mediastinoscopy, etc.
4. Respiratory Distress Syndrome.

The scientific session will conclude with an address by Dr. John B. Hickam, Professor and Chairman, Department of Medicine, Indiana University School of Medicine. ◄

Deaths

Robert L. Armington, M.D.

Dr. Robert L. Armington, practicing Anderson physician since 1934, died Sept. 2 at his home. He was 62.

Graduated from the Creighton University Medical School in Omaha in 1933, Dr. Armington was a general practitioner. He had served in the Medical Corps in the U.S. Armed Forces in World War II, retiring as a captain, and was a member of the Madison County Medical Society.

Herbert F. Call, M.D.

Dr. Herbert F. Call, 65-year-old Indianapolis pediatrician, died Sept. 1 in Methodist Hospital.

A world traveler and sportsman, Dr. Call was graduated from the I.U. School of Medicine in 1929. He opened his first office in Indianapolis in 1932 and eventually had one of the largest pediatric practices in Indiana. He was a member of the Marion County Medical Society.

Edward W. Custer, M.D.

Dr. Edward W. Custer, 61, superintendent of Healthwin Hospital, South Bend, died Aug. 30 in the New England Baptist Hospital in Boston, Mass.

Before going to South Bend, Dr. Custer was assistant medical director of the State Tuberculosis Sanitarium in Hamburg, Pa. A victim of tuberculosis himself, Dr. Custer was one of the first patients to be treated for the disease in the Healthwin Hospital after its remodeling in 1949. He assumed the head post in 1951 and continued his duties from his bed at the time of his illness. He was graduated from the Jefferson Medical College in 1933 and was a member of the St. Joseph County Medical Society.

Robert L. Gammieri, M.D.

Dr. Robert L. Gammieri, Indianapolis general practitioner, died Aug. 28 at home at the age of 48.

Dr. Gammieri had practiced medicine in Indianapolis 20 years after being graduated from the I.U. School of Medicine in 1944. He served in the U.S. Army in World War II and was a member of the Marion County Medical Society.

Allan K. Harcourt, M.D.

Dr. Allan K. Harcourt, industrial surgeon who specialized in hand surgery in Indianapolis, died Aug. 28 in Methodist Hospital. He was 71.

A 1922 graduate of the I.U. School of Medicine, Dr. Harcourt was a partner in the Indianapolis Industrial Clinic from 1926 to 1967 when he built his own clinic. He started many industrial safety programs in Indianapolis, was a medical advisor to Wheeler Mission and was former medical director for the Indiana Bell Telephone Co.

On the staffs of the Methodist, Community and St. Vincent's Hospitals, he was a Senior Member of ISMA and member of the Marion County Medical Society.

Eli L. Levin, M.D.

Dr. Eli L. Levin, 75, physician in Indiana Harbor for 53 years and the oldest practicing physician in both St. Catherine and Gary Methodist Hospitals, died Aug. 9 in St. Catherine Hospital, East Chicago.

Graduated from the Chicago College of Medicine & Surgery in 1917, Dr. Levin served as a first lieutenant in the Army Medical Corps. He was a coroner-physician in the Lake County Coroner's Office for many years and a former member of the East Chicago Board of Health. He was a Senior Member of ISMA, member of the 50-Year Club and the Lake County Medical Society.

Arthur Rogers, M.D.

Dr. Arthur Rogers, one-time Newburgh physician, died in Chicago the third week in July. He was 48.

Former president of the Warrick County Medical Society, Dr. Rogers left Newburgh in 1963, after practicing there about 15 years. He was graduated from Loyola University Stritch School of Medicine in 1952.

Elmer C. Singer, M.D.

Dr. Elmer C. Singer, 80, Fort Wayne general practitioner, died Aug. 13 at his home.

Dr. Singer, a native of Monroe Township, was graduated from the Hahnemann Medical College in 1913. He began his practice in Fort Wayne in 1942, after serving in the first World War in France and Germany. He became physician in charge of school physicians in Fort Wayne public schools, served as police surgeon from 1922 to 1926, and vice-president of the Board of Health in 1928-30. He was a past-president of the Fort Wayne Medical Society, member of the board of directors of the Fort Wayne Medical Society, secretary of the medical staff of St. Joseph's Hospital and medical director of the Tuberculosis Association of Allen County.◀

COMMERCIAL ANNOUNCEMENTS

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Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

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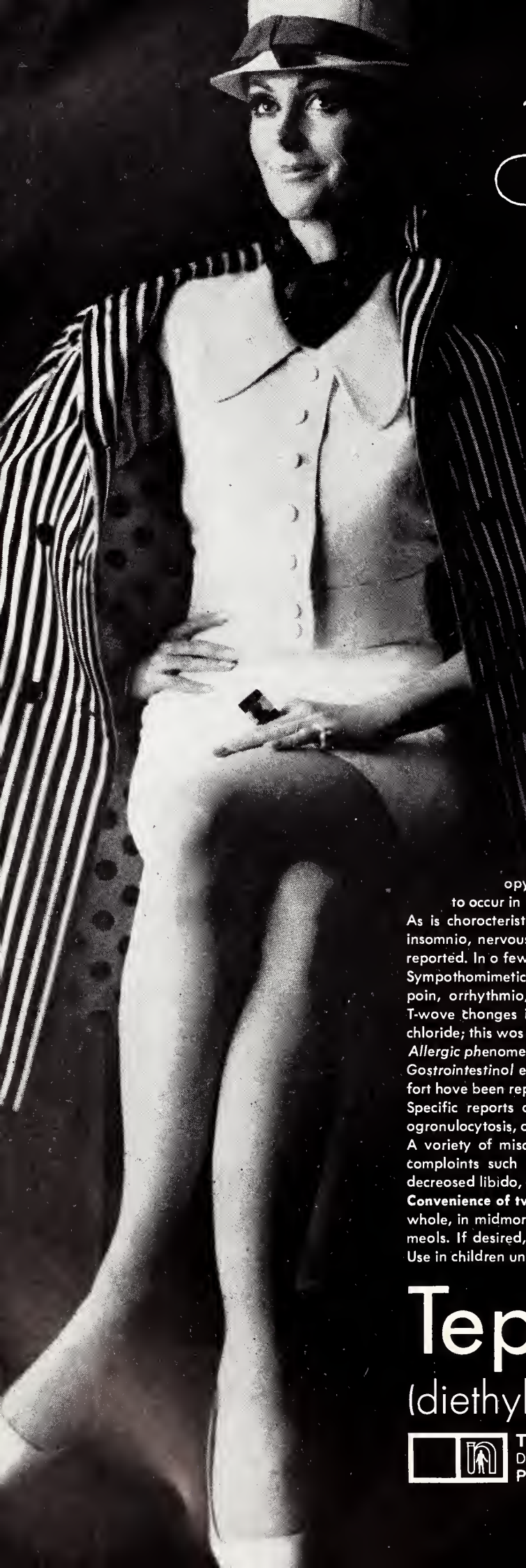
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Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others.

Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema.

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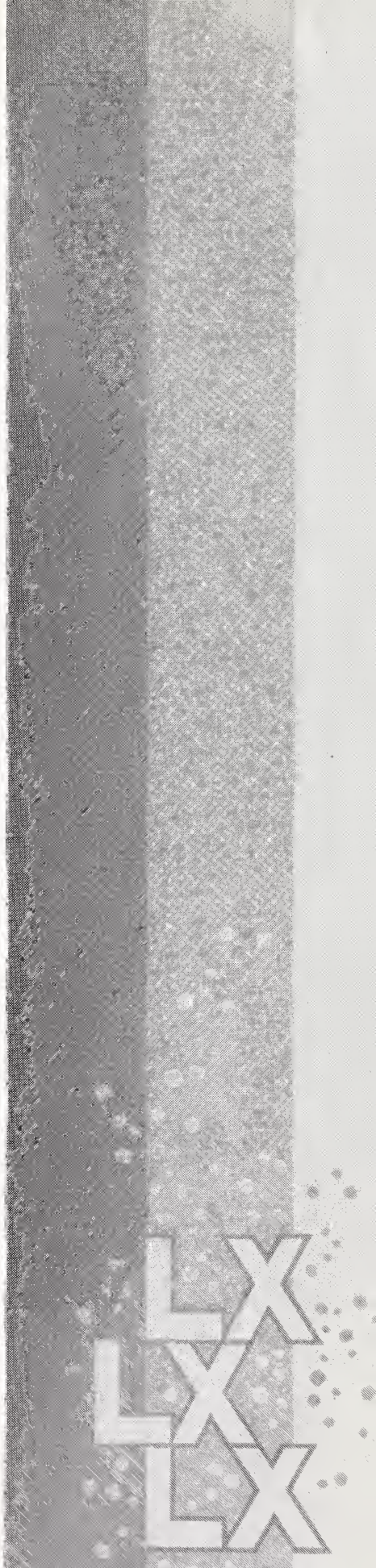
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(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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Office of Publication

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Contents

SCIENTIFIC

Recognition and Management of Hypokalemia, James T. Higgins, Jr., M.D., Indianapolis 1299

Subglanular Urethral Fistula from Infant Circumcision, Jack T. Lackey, M.D., Hines, Ill., Rodney A. Mannion, M.D., Hines, Ill., John E. Kerr, M.D., Michigan City 1305

Persistent Problems in Medical Care, Wilbur J. Cohen, Ann Arbor, Mich. 1310

Electrocardiogram of the Month: Pacemaker Electrocardiography (IV), Charles Fisch, M.D., Indianapolis 1316

X-Ray Conference: Arteriographic Assessment of Viability of Bowel After Perforating Abdominal Injury, Erich K. Lang, M.D., Shreveport, La. 1322

EDITORIALS

Indiana Medical Foundation 1326

Inflation is a Leaky Bucket (Guest) 1326

Editorial Notes 1327

SPECIAL FEATURES

Lowell H. Steen, M.D., President, 1969-70 1334

Indiana Regional Medical Program, George F. Leamnson, Director of Community Relations, Indianapolis 1339

REGULAR FEATURES

What's New? 1285

Month in Washington 1288

Fourth Estate 1292

From The Journal 50 Years Ago 1324

The Woman's Auxiliary Reports to ISMA 1328

Indiana's Health Care Bill in 1968 $1,020,000,000 (One of a Series) 1336

Medicine At Law 1344

Abstracts, Book Reviews 1349

Board of Health Report 1352

News Notes 1357

Annual Meeting Dates of Professional Medical and Allied Organizations 1368

Future Meetings, Seminars, Courses 1369

County, District News 1370

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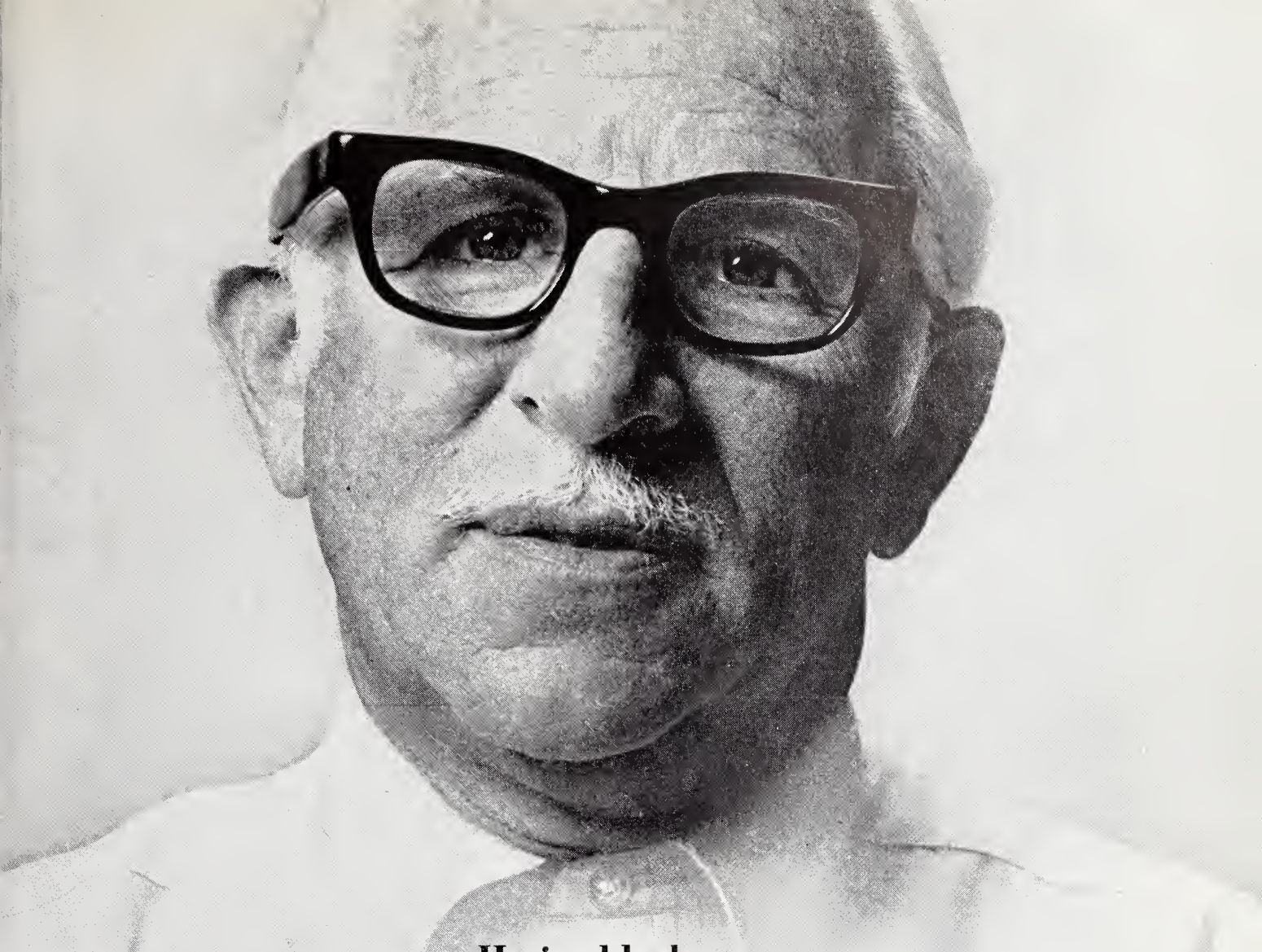
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3—Elmer L. Wallace, New Albany	197
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5—Cleon M. Schauwecker, Greencastle	197
6—David E. Wynegar, Richmond	197
7—John O. Butler, Indianapolis	197
8—Paul Sparks, Winchester	197
9—Lindley Wagner, Lafayette	197
10—Thomas C. Tyrrell, Calumet City, Ill.	197
11—James A. Harshman, Kokomo	197
12—Frederic L. Schoen, Fort Wayne	197
13—G. Beach Gattman, Elkhart	197

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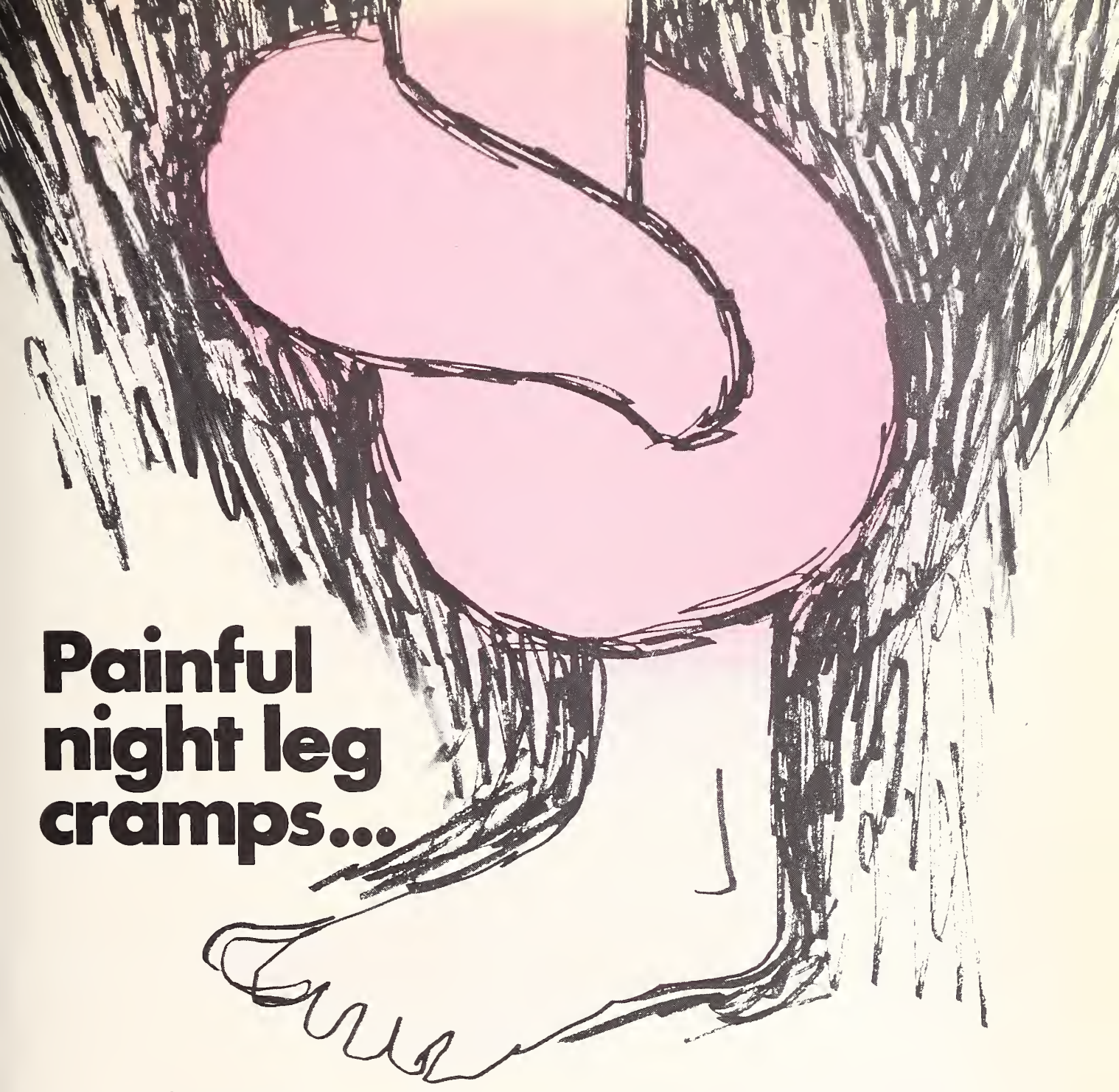
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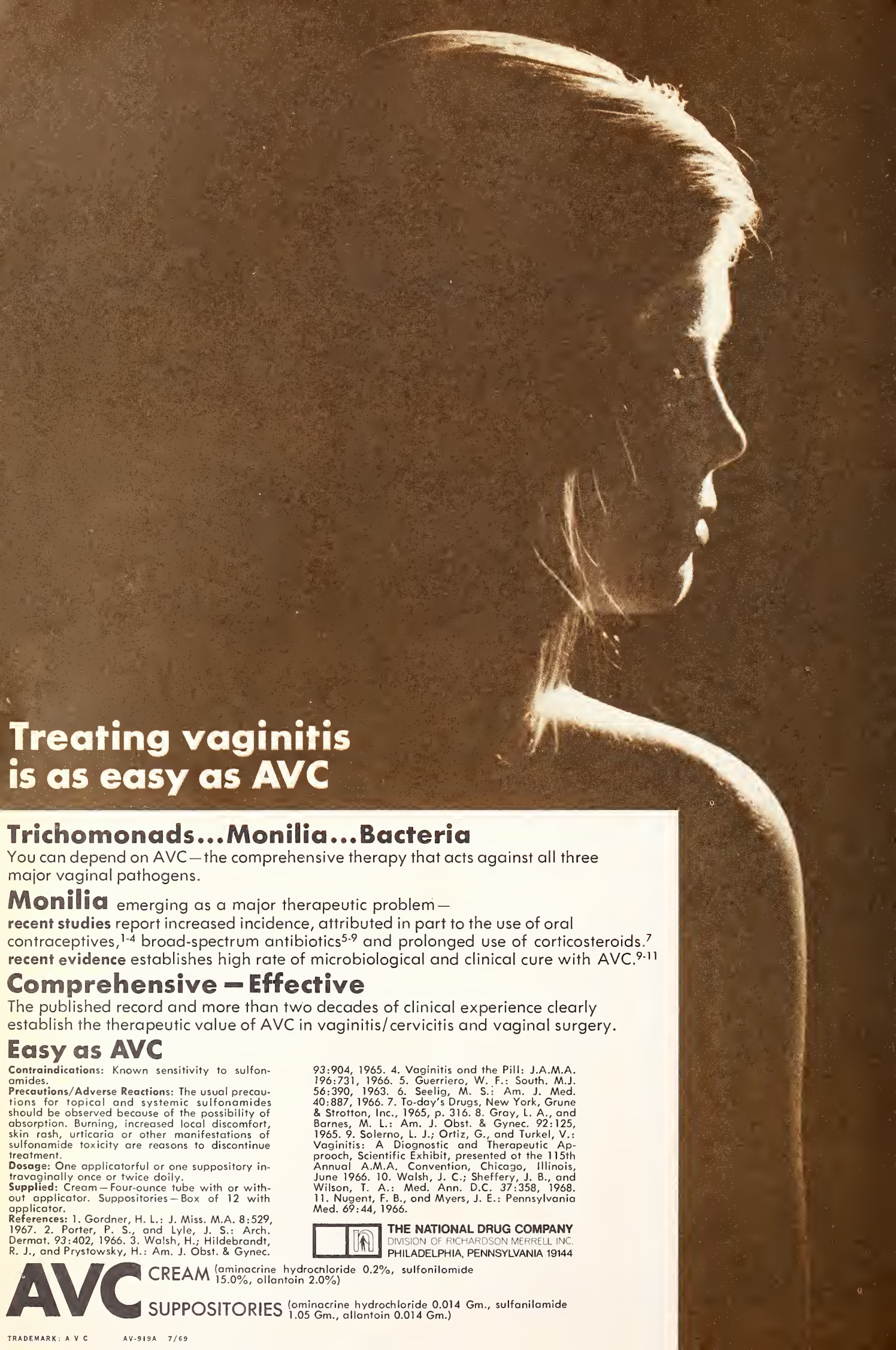
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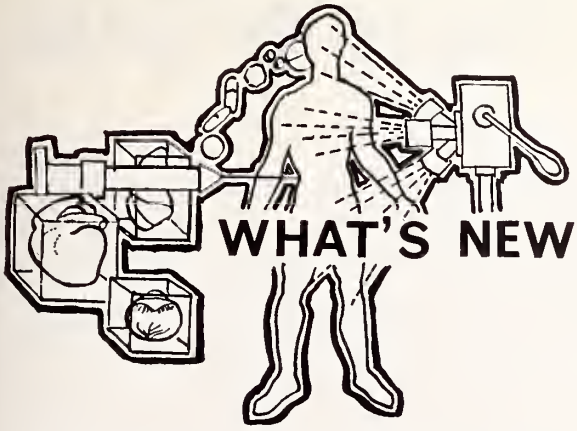
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References: 1. Gordner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis ond the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Strotton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Solerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diognostic and Therapeutic Approoch, Scientific Exhibit, presented ot the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., ond Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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* * *

A new handy 96-page "Professional Storage Planning Manual", by Bernard Franklin Co., is available and is recommended for doctors who have need for the latest information on equipment and methods for space-saving storage. The book is especially valuable for hospitals or medical groups with limited storage space. Doctors may obtain a free copy by writing on their business letterhead to Bernard Franklin Co., 4045 Torresdale Ave., Philadelphia 19124. Mention this journal and include your zip code. To those not in the medical and health field the price is $1.50.

* * *

"Synanon" is the name of a book by Guy Endore about an organization by the same name dedicated to aiding and curing drug addicts. Mr. Endore has worked with the organization for many years and, in the book, tells of its aims and progress since its inception in 1958. The book is published by Doubleday—408 pages—$5.95.

* * *

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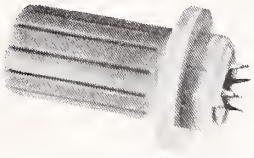
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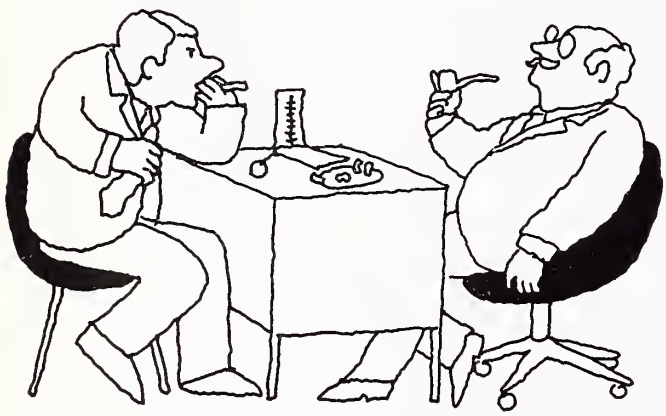
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THEN WE HAVE TO LOSE WEIGHT. 20 POUNDS SHOULD DO IT... WE'LL TALK A LITTLE LATER ABOUT THIS DIET WE'RE GOING TO START.

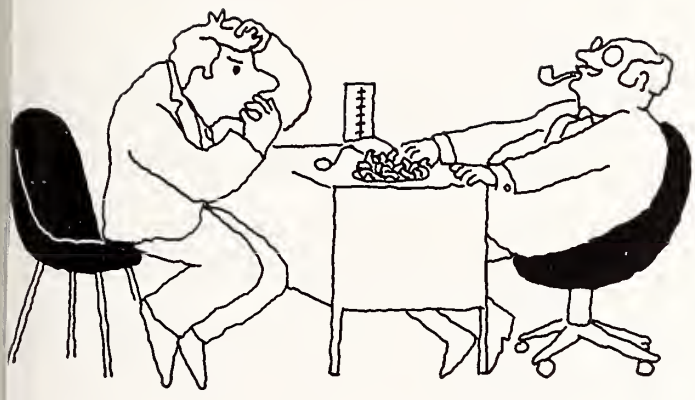


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MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

WASHINGTON, D.C.—Health, Education and Welfare Secretary Robert Finch has asked a special Task Force on medicaid to examine and make recommendations on proposals for a sweeping national health program.

THE TASK FORCE, headed by Walter J. McNerney, president of the Blue Cross Association, is scheduled to issue a report about the first of the year.

AFTER REFERRING to a proposal for universal health insurance endorsed by many governors at the National Governors' Conference, Finch told McNerney in a letter:

"I WOULD like specifically to request that the Task Force consider, along with its other deliberations on medicaid and related programs, what directions and initiatives you feel the HEW Department should pursue in this area."

ACCORDING TO McNerney, one phase of the study would include the extension of medicare to persons of all ages, roughly the national compulsory health plan backed by Walter Reuther of the United Auto Workers and his Committee of 100 for National Health Insurance.

McNERNEY, HOWEVER, also said that all types of mass plans would be studied, including the health insurance tax credit proposal endorsed by the American Medical Association.

THE RAPIDLY rising costs of medicare and medicaid have brought the issue to the forefront. The Administration said older people who enter the hospital after January 1 will have to pay for an additional $8 of their hospital bills due to the higher costs. The increase is required by law.

THE BENEFIT CUTBACK results from an adjustment of the portion of the hospital bill for which a medicare beneficiary is responsible if these costs have risen substantially.

FEDERAL HEALTH EFFORT "PLANLESS," SAYS RIBICOFF

AFTER A two-year study, Sen. Abraham Ribicoff (D., Conn.), former HEW Secretary, said he's reached the conclusion the federal health effort "is a planless conglomeration of programs administered by more than a score of agencies and departments."

FEDERAL HEALTH SPENDING "instead of supporting programs to provide for the health of the people. . . is maintaining a cumbersome, disjointed bureaucracy that even key government officials have difficulty managing," he told the Senate.

"INSTEAD OF eliminating problems, [they] may be adding to factors such as rising costs, limited access to care and the fragmented organization of health services."

"THERE ARE SO MANY programs administered in such bureaucratic confusion that no one—not the HEW Department, not the Bureau of the Budget nor any private organization was able to tell the subcommittee even how many programs there are."

AMA SAYS DRUG DEPENDENT PERSONS ARE NOT CRIMINALS

THE AMERICAN Medical Association told Congress drug dependent persons should be treated as patients rather than criminals.

IN TESTIMONY before the Senate Juvenile Delinquency Subcommittee, Henry Brill, M.D., chairman of the AMA's Committee on Alcoholism and Drug Dependence, said physicians are concerned over legislation before the subcommittee proposing harsher penalties for persons unlawfully possessing drugs for their personal use.

"MERE POSSESSION for personal use of depressant and stimulant drugs having a legitimate medical usage should not constitute an offense," Dr. Brill said. "The degree of social hazard and the reasons for having the drug should be taken into account."

"WITH RESPECT TO the entire section on offenses and penalties, we propose an amendment to direct courts to appoint a panel of medical experts in each case where a drug abuser is brought to trial on a charge of illegal possession and where, in the court's opinion, medical treatment may be indicated. The panel would make a determination as to whether the defendant has a medical problem associated with his abuse of drugs--a physical or psychological disability or drug dependence.

"IF MEDICAL TREATMENT is indicated, the panel would recommend to the court the type of treatment needed—that is, general—medical or psychiatric care; inpatient hospitalization or clinical treatment; group therapy; half-way house, etc. If medical treatment is not indicated, or if measures in addition to medical treatment are needed, the court would then consider the non-medical handling of the case."

UNDER THE PROPOSED AMA changes, the HEW Department, rather than the Justice Department, would control the official classification of drugs, and the research and public education programs in the field. Control provisions would focus on manufacturers and distributors, rather than on physicians.

"WE RECOMMEND that as a matter of public policy Congress explicitly charge the HEW Department with the major responsibility for research on all aspects of drug abuse and dependence other than enforcement," said Dr. Brill.

THE AMA SUPPORTS provisions in the legislation "which would allow researchers to withhold names of subjects, and to handle controlled drugs without prosecution, especially on state and local levels, has served to hamper needed research in the past."

Continued

AMA SUPPORTS MORE TRAINING FOR FOREIGN MEDICAL GRADUATES

THE AMERICAN MEDICAL Association supported legislation to require foreign medical graduates trained in this country to spend two years of residence in their native land or land of previous residence before becoming eligible to apply for U.S. citizenship.

C. H. WILLIAM RUHE, M.D., director of the AMA's Division of Medical Education, said the measure would strengthen the Exchange Visitor Program. However, Dr. Ruhe suggested that the provision be strengthened to require that citizens of less-developed nations return to their home countries rather than their latest nation of residence. He cited the example of citizens of India who come to the United States from England.

"IF SUCH participants are required merely to return to England there will be no alleviation of the brain drain from India," he told the House Judiciary Subcommittee on Immigration.

HEW CHILDREN'S BUREAU REORGANIZED

THE HEW DEPARTMENT'S Children's Bureau was broken into separate health and welfare units.

Under the reorganization:

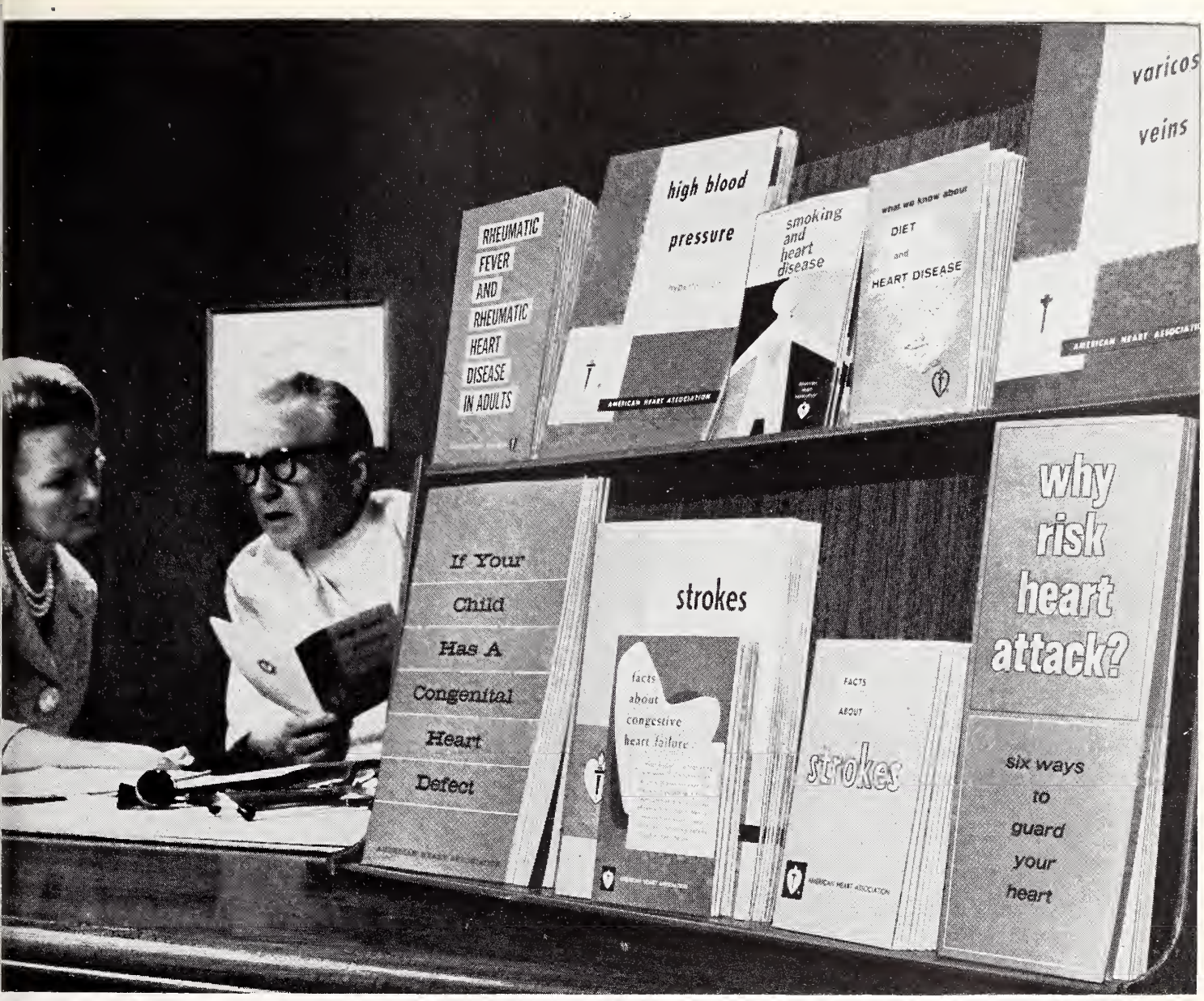
*HEALTH PROGRAMS administered by the Children's Bureau were transferred to the Health Services and Mental Health Administration (HSMHA) where they will form a new organization unit. Programs included are for maternal and child health services, crippled children, maternity and infant care, and health of school and pre-school children.

*THE CHILDREN'S BUREAU as such goes from the Social and Rehabilitation Service to the Office of the HEW Secretary, where it becomes part of the new Office of Child Development. The bureau will maintain its role of leadership and coordination of child and parent programs throughout the department. It will also continue to investigate and report on all matters pertaining to the welfare of children.

*COMMUNITY SERVICES administration is established in the Social and Rehabilitation Service to consolidate the administration of social service programs for children and adults. These include programs located previously in the Children's Bureau and in other agencies of the Social and Rehabilitation Service.

"I EXPECT the Office of Child Development and the Children's Bureau to be vigorous advocates of the interests of children," HEW Secretary Robert Finch said. "They will work directly with public and private agencies to stimulate improvements in the availability and quality of services to children and parents, and to work with all agencies of HEW."

SECRETARY FINCH said that maternal and child health programs will be strengthened by their placement in HSMHA. "All of the health programs administered by HSMHA should benefit from this new and closer relationship," the secretary said. ◄



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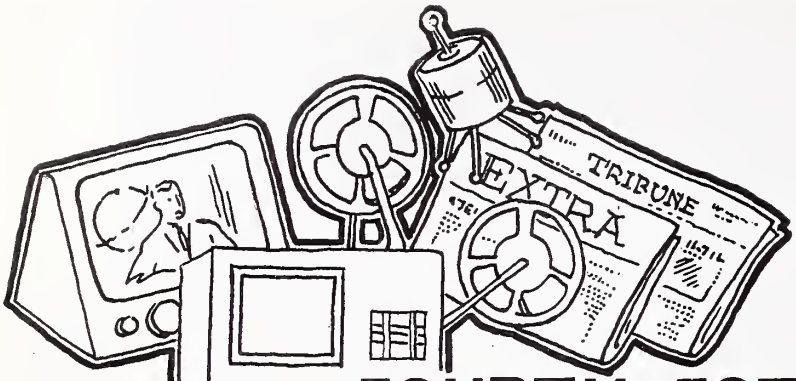
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FOURTH ESTATE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Medical Training Plan

State Sen. Albert LaMere and Sen. Vance Hartke are working on a novel plan for providing Indiana's Calumet Region more physicians.

It calls for using region hospitals as the clinical training grounds for about 20 senior medical students and the regional facilities of Indiana or Purdue universities for classroom work.

In charge of the program would be a small staff of a director and several assistants.

Ultimately the program would be expanded to include 25 freshmen medical students.

The Department of Health, Education and Welfare is reported interested in the plan. Funds for financing it would have to be sought through Indiana University which has the state's only medical school. It is estimated about $500,000 is necessary.

The program is something of a reverse of what occasionally happens in medical training: Students take their first two years of study — mostly didactic — at an institution other than where they receive their clinical training their final two years.

Good facilities for didactic work are not too hard to provide; the clinical end is a different story since a sizeable hospital and a broad spectrum of patients are necessary if instruction and learning are to be worthwhile. There must, of course, be a teaching staff of physicians.

The region has an ample supply of hospitals containing a variety of medical and surgical cases and a large pool of practicing physicians.

The program is worth serious consideration, particularly if it opens the way to eventual establishment of a complete medical school in this part of the state.—*Hammond Times*, June 4, 1969.

Recognizing the Need for Doctors

It is hoped that the powers that be in Indiana — currently essentially Republican — noted one salient point of the Republican Nixon administration's health plans outlined in a Chicago speech the other day.

The speaker was Health, Education and Welfare Under Secretary John G. Veneman. He was addressing the American Hospital Association convention.

The point we underline was the cited need for more doctors, nurses and non-professional aides treating the ill.

Two area institutions — the Calumet Purdue campus and Calumet St. Joseph College — both have added programs for more training of nurses and hospital technicians.

That leaves Indiana, of course, in precisely the same bind it has been in for years. It is graduating too few doctors.

Which gets back to the point of Indiana's need for at least one more state medical school, possibly more. If only one such school were added we still say it should be located in Northwest Indiana where the need is sorest because of the sizable and still growing population.

Hopefully, the Nixon administration may back up its recognition of the need by making more federal funds available for training doctors. If that is the case, the state certainly should be preparing to take advantage of such funds. The last legislature shelved the problem. That was in part due to the heavy politi-

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cal pressures from various parts of the state each of which wants such a school.

But the pressure of public need should override the pressures of politics. Like the man said, one of the pointed needs is for more doctors. —*Gary Post-Tribune*, Aug. 23, 1969.

Bowen Speaks Up

Indiana House Speaker Otis R. Bowen again is facing up to reality, while Gov. Edgar Whitcomb sits in his statehouse office and wishes it would go away.

This time the issue is reapportionment of the state legislature, as ordered by the federal courts, to meet the Supreme Court guidelines for equality of voting districts.

A federal court panel has ordered the legislature to prepare a redistricting plan by Oct. 1. If this is not done, the judges will draw up a plan of their own and order it into effect. The legislature can act only if the governor calls it into special session.

Quite clearly redistricting must be done to fit the Supreme Court's ruling. The state's districts are seriously out of balance. Instead of plunging into the matter, however, the governor is trying to postpone it by appealing to the Supreme Court for a delay. The high court does not convene until October, after the lower court's deadline for action.

The logical thing would be for Whitcomb to call an immediate special session and prepare an acceptable redistricting plan. But he has refused. Obviously he is afraid that if the legislators convene they will reopen consideration of much-needed state tax reform and other issues he finds uncomfortable.

Bowen has stepped into the breach of leadership by challenging the governor to call the session and do something positive.

If the governor allows this situation to drift, Indiana will end up with a redistricting plan drawn up by a federal court, instead of one prepared by its own legislature.

This would be an inexcusable abdication of state authority, for which the governor would be responsible.

When congressional districts were remapped, the Democrats complained because the decision was made by a Republican-controlled panel of judges. The new legislative map would be drawn by a Democratic-dominated judicial panel. Surely our Republican governor doesn't want this to happen.—*South Bend Tribune.*

Interim Med School Hope

The newly unveiled program of training additional doctors partially in this area is welcome if—

If, that is, it is recognized primarily for what it should be—a stopgap or interim program.

Efforts should continue, meanwhile, to push for a full-time state medical school in Lake County which so sorely needs it and so richly deserves it.

Under the program disclosed here last week by industrialist Beurt Ser Vaas, chairman of a task force appointed by Gov. Edgar D. Whitcomb, beginning in the fall of 1970 one or two years of medical training would be available for prospective doctors in Northwest Indiana and five other districts of the state.

After those two years the partially trained doctors would go to Indianapolis, site of the state's only existent medical school, for their third and fourth years of training.

Following graduation they presumably would return to this and the other training areas for their hospital internships. The hope is that would guide them into staying in the areas in which they got their early and late training.

If, as Ser Vaas hopes, such a system would double the number of Indiana medical school graduates, it should be implemented as soon as practical — in other words within a year. The need for doctors is much too sore throughout much of the state, and particularly in this second most populous Hoosier area, to wait the time required for setting up a full-time medical school.

However, the need for a full-time school here would remain. The need for doctors is growing nationally. This area is continuing to grow which means the need for doctors here will continue to grow also.

In time, Lake County deserves to be the site of a second Indiana University medical school. The fact that there has been stalemated political warfare over the issue in the last two sessions of the Indiana legislature should not halt the effort.

Ser Vaas expressed the opinion that such a training program as he suggests might be developed by any one of the six areas into a full-time medical school. Every effort should be pressed to make that dream come true. But that effort should definitely include getting across the message to the state that state support for a medical school in its second most populous area is deserved.—*Gary Post-Tribune*, Sept. 9, 1969.

Bowen's Alert, but Who Else?

Indiana House Speaker Otis R. Bowen is demonstrating a personally typical alertness in his reaction to the problem of Indiana legislative reapportionment. The fear is that it may — again typically — be insufficiently shared.

Dr. Bowen (he's a Bremen physician when not legislating), it should be recalled, was also alert during the last session to the need of major Indiana tax revision with a primary eye to property tax relief. He could not, however, rally a sufficient number of the rest of the Hoosier Republican legislative majority — or the Democratic minority — or support of the Republican executive

branch to turn that concern into action. Owners of homes, farms and businesses go on carrying too much of the tax load as a consequence.

Now Bowen is alerted by the federal court order which has found that Indiana's present system of countywide, often multiple, and definitely irregularly sized state House and Senate districts, deprive some, particularly minorities, of the legislative representation to which they are theoretically entitled under the U.S. Supreme Court's "one-man-one-vote" concept.

He realizes that there is nothing the legislature can do until the Supreme Court rules on an appeal from the three-judge panel. It ordered legislative action on setting up more representatives by Oct. 1. However, he also realizes that that decision just might come with no time left for action. Even should the higher court grant an extension from the unrealistic Oct. 1 date, not much time would be allowed. It would remain imperative for the districts to be set before the filing period for new legislative seats early next year.

Bowen has asked the other 99 members of the House for their suggestions on setting up single-member districts. But is he acting alone?

Lt. Gov. Richard Folz, ex-officio presiding officer of the State Senate, says he has no like plans for a similar survey. Gov. Edgar D. Whitcomb, who would have to call a special session before legislative action could be realized, has, so far as we know, taken no steps beyond appealing the three-judge decision. If the decision is overturned, then the governor would be proved right. If it isn't, then the state would be left facing an over-complex problem with much too little time. The result, in that case, probably would be redistricting by court fiat. That may be a necessity, but is hardly in the most democratic tradition.

But no one but Bowen seems much concerned. Incidentally, it is interesting to note he is polling legislators on the one-member district plan. That's not mandatory under the court holding. It would permit one-, two-, three-, or four-member districts so long as they were balanced by population. Again, though, we think Bowen is on the right track. The single member districts could provide the most responsive legislators, those most directly in key with the people who elect them. That's what representative government is about.

But does anyone but Bowen care? —*Gary Post-Tribune*, Sept. 11, 1969.

Progress In Medicine And Surgery

Americans watch with pride the advances in their country in the fields of medicine and surgery.

They are not unmindful that there is also great progress in these very important professions in other countries.

We think it may be said with truth that the long steps forward are nearer their beginning than their end.

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Each individual must do his best to keep his health and vigor by observing the rules of sane living. —*Fort Wayne Journal-Gazette*, Sept. 22, 1969. ◄

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Recognition and Management of Hypokalemia

JAMES T. HIGGINS, JR. M.D.*
Indianapolis

WHEN she arrived at the medical center admitting room, the young woman showed complete paralysis and could no longer move even the muscles of respiration. Ventilation was maintained only by positive pressure assistance. Although she was totally unable to respond, the attending physicians felt that she was conscious and aware of her surroundings and condition. This made drug overdose very unlikely, and other causes were sought.

Her husband denied an antecedent illness suggesting polio or Guillian-Barre syndrome, and a careful search of the patient's skin and hair revealed no ticks. Obviously more unusual causes of paralysis had to be considered, and many complicated theories were being proposed by the excited and perplexed physicians when the results of emergency laboratory studies began to come in.



The astonishing disclosure of a serum potassium of 1.3 mEq/L left no doubt about the pathogenesis of the paralysis and its treatment. Parenteral potassium therapy brought about an almost immediate reversal of the paralysis, and within the next couple of days, the additional findings of excessive renal loss of potassium and a persistently alkaline urine in the presence of hypokalemia and systemic acidosis established the diagnosis of renal tubular acidosis.

This dramatic, unusual and nearly tragic case history illustrates the seriousness of potassium depletion syndromes, even in a young and otherwise healthy woman who was on no medication. Had she been older, debilitated, had ischemic vascular disease, or been on digitalis the outcome probably would not have been so happy.

The ready availability of serum electrolyte determination, routinely obtained on all patients in some hospitals, is leading to the more frequent recognition of electrolyte disturbances, and one of the most common of these disorders is hypokalemia. Although improved laboratory technology has contributed to the increased recognition of hypokalemia, there is no doubt that more extensive use of drugs such as diuretics and steroid hormones has led to an increase in the incidence of this disorder.

The purpose of this brief paper is to review some of the more common causes of hypokalemia, and their treatment. Unlike the serum sodium concentration, the serum potassium concentration is considered a reasonably accurate indicator of the total body content of potassium, at least in qualitative terms. Thus a reduced serum potassium level almost always reflects a depletion of the body stores of potassium, although it does not indicate the magnitude of the depletion. It is convenient and not at all an oversimplification to think of potassium depletion as a state brought about by inadequate intake, by excessive excretion, or by both.

Deficient Potassium Intake

The human kidney does not have an efficient mechanism for the conservation of potassium, and despite an inadequate intake, the normal individual excretes potassium at a rate of 10-20 mEq/24 hr. Even after

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Dr. Higgins is a recipient of U. S. Public Health Service Career Development Award HE 42403 of the National Heart Institute.

severe depletion of potassium occurs, its excretion continues at a rate of about 5 mEq/24 hr. Thus a person with normal renal function can be expected to develop hypokalemia if deprived of dietary potassium during the course of some unrelated illness, and this condition is made worse if in addition there is excessive loss of potassium as described below.

So long as there is no renal disease which might cause azotemia and excessive potassium retention, potassium supplementation can be given without worry. When oral intake is possible, this route is preferable. Either potassium salts or fruits and fruit juices may be given, although the latter are obviously more palatable. If replacement must be given intravenously, 40 mEq potassium each day is usually sufficient, although this amount may be doubled or tripled if potassium depletion exists. Because of potential cardiac toxicity, potassium administration should be evenly spread throughout each 24 hour period, especially at higher doses.

Excessive Gastrointestinal Loss of Potassium

Gastrointestinal loss of potassium may occur through vomiting or diarrhea. There is a fundamental difference between the two because the attendant losses of hydrogen ion and chloride during vomiting may cause alkalosis in addition to hypokalemia. This condition requires not only supplementary potassium but chloride as well. The chloride need exceeds that provided with potassium as KCl, and usually is provided by NaCl. Since vomiting and diarrhea are frequently accompanied by dehydration, and since supplemental chloride is almost always given as the sodium salt, the patient's state of hydration and cardiovascular condition must be kept in mind.

If parenteral therapy is indicated, 20-60 mEq KCl may be added to each liter of fluid, depending on the degree of potassium depletion. Proprietary electrolyte solutions may accomplish the same goal, but these do not allow the flexibility of "do it yourself" solutions. Fruits or juices may be contraindicated in diarrhea, and oral potassium salts may be necessary.

Excessive Renal Loss of Potassium

The specific intrarenal mechanisms which lead to increased potassium excretion are complicated and not entirely understood. From a clinical standpoint, however, the situation is somewhat simpler since most instances of excessive potassium excretion are the result of any one or a combination of three common causes: diuretic therapy, excess adrenal cortical hormone (endogenously secreted or exogenously administered), and specific potassium-losing nephropathies.

The widespread use of thiazide diuretics and the introduction of such extremely potent diuretics as furosemide and ethacrynic acid has resulted in an increased incidence of hypokalemia. By blocking sodium reabsorption in proximal portions of the renal tubule, these drugs cause an increased delivery of sodium to the distal tubule. There a portion of the sodium is reabsorbed in exchange for potassium and hydrogen ions, which are excreted in the urine. Since sodium conservation appears to take precedence over maintenance of potassium balance, negative potassium balance may result. Excessive potassium excretion is exaggerated if secretion of aldosterone is elevated, as it is in most of the edematous states for which diuretics are given. There is also evidence that these diuretics inhibit carbonic anhydrase, the enzyme which makes hydrogen ion available for exchange with sodium in the distal tubule. If either these drugs or systemic alkalosis limits availability of hydrogen ion, potassium excretion is potentiated.

Adrenal steroid hormones, as mentioned above, stimulate distal tubular sodium reabsorption in exchange for potassium and hydrogen ion which are excreted. All adrenocortical hormones, even synthetic "glucocorticoid" hormones such as prednisone, possess this property in varying degrees with aldosterone being the most potent. The most severe instances of steroid-induced hypokalemia are these occurring in patients with aldosterone-secreting adrenal tumors, but hypokalemia is also common in Cushing's disease and in patients treated with steroids.

The only problem in the diagnosis of drug-induced hypokalemia is obtaining an accurate history, especially from a patient with more than one doctor. The diagnosis of excessive endogenous secretion of adrenocortical hormones may be difficult, and is beyond the scope of this review. In any of these conditions, the treatment is aimed at removing the offending agent when possible and replacing potassium losses.

Primary potassium-losing nephropathies are very rare. With the exception of renal tubular acidosis, which can be diagnosed as in the case above, this condition must be diagnosed by excluding all other causes of excessive urinary potassium excretion. In addition to supplemental oral potassium, restriction of dietary sodium is helpful in these cases.

Conclusion

Potassium depletion and hypokaemia will be recognized frequently by the careful clinician who is on the watch for this condition. The etiology can usually be determined by careful history taking. Treatment is accomplished by giving supplemental potassium, and by removing the cause whenever possible.

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JOHN T. LACKEY, M.D.*
RODNEY A. MANNION, M.D.**
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CIRCUMCISION is considered a simple procedure but distressing complications may occur following it.[1,3,7,9] We have observed urethral fistulae as a result of circumcision performed with a plastic bell[5] and the Gomco clamp. These fistulae were 1 to 2 cms. proximal to the urinary meatus beneath the glans. All were secondary to the use of a mechanical device. Postoperative hemorrhage occurred in all three cases. No associated genital anomalies were previously noted and none of these fistulae were noted until four or five months of age.

Case Reports

Case No. 1 (LaPorte Hospital No. 66-2651). A full term, normal child was born on 3-22-64 and circumcision with the Gomco clamp was performed four days later. Bleeding complicated the circumcision. Sutures were placed on the posterior aspect of the corona to control bleeding.

The patient was referred for evaluation of urethral fistula in 1966. After he began to void without diapers, the parents noted an extra opening on the ventral aspect of the urethra. On 6-20-66 perineal urethrostomy for urinary diversion and excision, inversion and repair of the fistulous opening were performed. A two layer closure was done. In this case there were two small separate openings (Figure 1). Healing was satisfactory and it was possible to remove the catheter on the 11th postoperative day. No postoperative complications occurred, and the fistula remained closed.

Case No. 2 (LaPorte Hospital No. 11542-3157). A normal male infant was born on 8-8-63. A Gomco clamp was used for circumcision on the second day. Postoperative bleeding was controlled by sutures placed at the mucocutaneous junction. A subglanular fistula became apparent after four months. He was hospitalized at age 3½ years and the fistula was repaired on 8-21-67. The postoperative course was uncomplicated (Figures 2 and 3).

Case No. 3 (St. Anthony Hospital No. 63-74). A normal male child was delivered 1-4-63 and a plastic bell device was used for circumcision immediately after birth. Postoperative bleeding was noted the following day and was controlled by pressure with a vaseline gauze dressing.

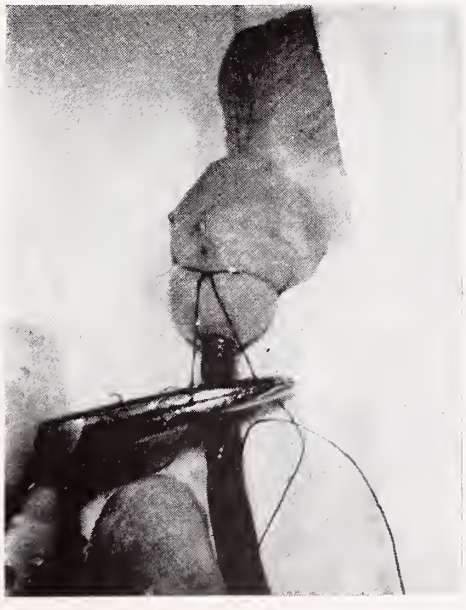


FIGURE 1
FLUID is seen flowing from the double fistula.



FIGURE 2
SUBGLANULAR urethral fistula from infant circumcision.

A pediatrician referred the child for evaluation of subglanular urethral fistula on 1-31-66, when the child was age three. Surgery was performed on 8-29-67. A urethrostomy catheter was left in place for drainage. After 24 hours edema and scanty drainage from the catheter occurred and extravasation was suspected. The patient subsequently had suprapubic cystotomy. The repair of the fistula was unaffected and healed satisfactorily.

Excision of the subglanular fistulae were done in the same manner in each case and two layer closure with 0000 chromic suture accomplished. Perineal urethrostomy with a Robinson catheter held in place with a silk suture was the method of urinary diversion.

Discussion

Trauma to the urethra, secondary to suturing because of postoperative hemorrhage is a cause of necrosis

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of the urethra. Another cause may be the placement of the clamp in such a way that the urethra is tented up into the clamp and incised. These fistulae occurred in the region of the frenum. Infection is a complication of circumcision resulting in persistent subglanular urethral fistulae, however, this did not occur in our series.[6] Hemorrhage did complicate the circumcision in our three cases, and it is reported that hemorrhage occurs in two percent of cases generally.[2] Nevertheless, there are no reported figures on fistula of the urethra following control of postoperative circumcision bleeding.

The plastic bell and Gomco clamp have been used extensively in performing circumcision. Few cases are reported and documented where urethral fistula was a complication, although Schulman[8] et al. reviewed 11 different complications of circumcision and did mention urethral fistula. They do not state how many they observed and do not mention a method of repair. Johnson[6] mentions one case of subglanular fistula secondary to infection which was repaired by the Davis method.[4] Byars[2] et al. had two cases of subglanular urethral fistulae following circumcision and discuss a method of repair related to urethroplasty for hypospadias deformities.



FIGURE 3
PLACEMENT of the perineal urethrostomy.

Summary

Three cases of subglanular urethral fistula following infant circumcision have been reported. Successful closure was obtained in each case. A method of repair is presented. Asepsis, operative technic and postoperative care play a role in the success of the urethroplasty.

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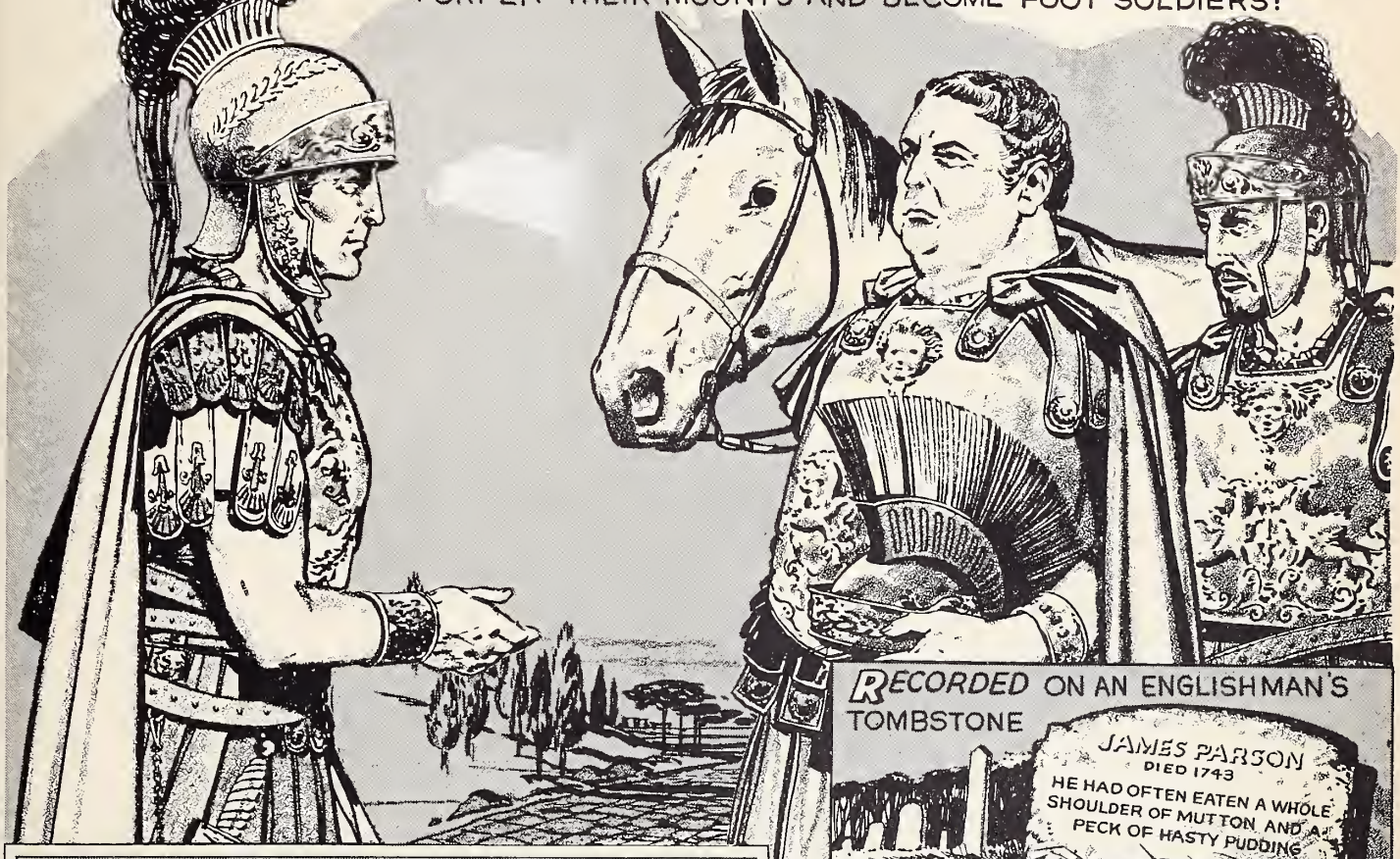
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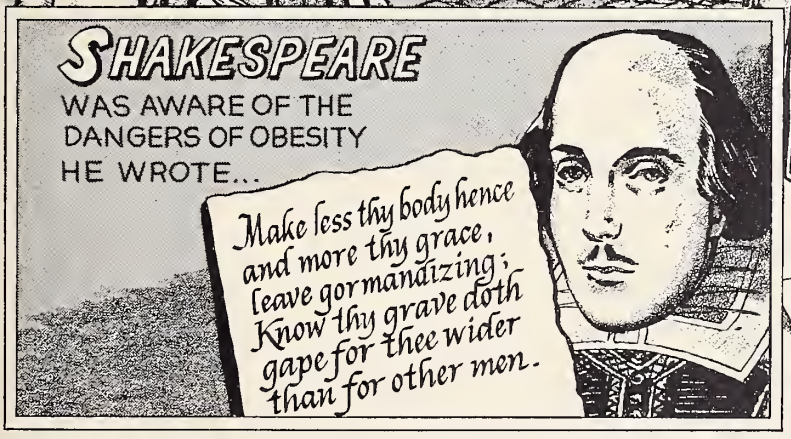
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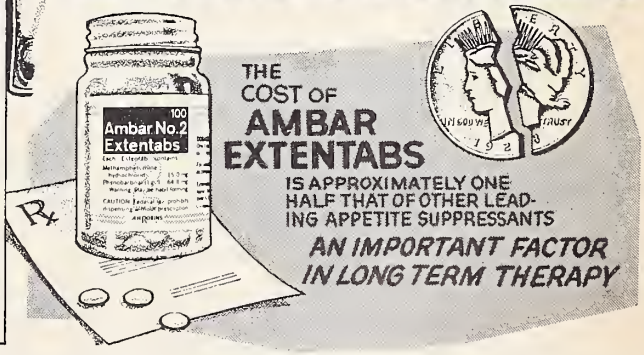
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Persistent Problems In Medical Care*

WILBUR J. COHEN**
Ann Arbor, Mich.

WITH some anxiety, some humility, some modesty, I come before you this morning to talk about some persistent problems. What I am going to talk to you about was what I once gave as a course that took 16 hours, so I don't think you can expect me this morning to be able to cover all of those aspects. I am just going to pick out a few that you might find of some interest.

Of course, the first one has to do with the problem of medical manpower. There is no question in my mind that as we look ahead to the decade of the 70's, and perhaps even beyond, the most persistent problem is the shortage of manpower and womanpower in the health professions.

Last year when I addressed the Medical Association of Deans of Medical Schools, I wholeheartedly supported the AMA-AAMC position that in the course of the next decade we should double the freshman class in medical schools from about 9,000 at the present time to about 18,000.

The same thing is true regarding nurses and other medical personnel.

But I believe it is very, very important and it is very incumbent upon the medical profession, and all the medical and health professions in this area, to work together with government in the development and expansion of medical schools on the construction side, in the expansion of faculty and in the student financial aid as perhaps the number one problem.

Rising Costs

Certainly, we all know that because of the problem of rising costs, it is obvious that if we have a continued shortage of professional personnel, prices will inevitably rise. There is no way to repeal the economic law of supply and demand. If supply is short and demand goes up which are the two things which will be happening during this decade, which has been happening the latter part of this decade, the problem will become even more intense.

As I speak later about the problem of extending the delivery of medical care to many people who don't have it, the problem of demand is going to become even more severe within the next ten years, and so, for that reason, I urge — I gently request and I suggest that the medical profession seek to work with government in the whole area of manpower.

It is absolutely essential, and I think there is very little controversy today as against ten years ago about the need for cooperation with government in the development of the financing of this important area.

Many millions of dollars are involved. I think if the medical profession were to work constructively with government, as I hope they will work with Dr. Egeberg, that it will be possible in the next few years to make a monumental impact on this problem, and no area of AMA-profession-government relationship has the possibility of greater constructive possibilities than were the medical profession now to enter wholeheartedly into this whole area. I think it will be possible. I am not pessimistic at all.

Revision of Curriculum

There is a second area that was discussed at that time that I think is important, and I do not feel competent to talk about it in detail but I read a good deal about it and that, I think, must involve a complete review and possible revision of the medical school curriculum.

I believe as I study the various aspects of the medical school curriculum that it is now too long and too complex and doesn't represent an adaptation to current needs.

As a matter of fact, in my speech last November at Houston, I recommended another Flexner Committee to completely review medical school education.

There are a number of other matters that I could express some views on.

I think a review of the whole method of how we pay interns and residents and whether the cost of that should be borne by hospitals as a patient cost or should be borne as an educational cost needs to be completely reviewed.

But in this manpower area, I think there is no reason that I can see for continued conflict or controversy. I think that the medical profession and those outside see eye to eye on general overall principles, and I would certainly believe that during this coming four to eight years with Dr. Egeberg here, there is no reason why the medical school

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* Adapted from a speech given before the Conference of Presidents and Other Officers of State Medical Associations, July 13, 1969, New York, N.Y.

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deans, the medical profession, those concerned about medical costs and medical ideals couldn't work together constructively to deal more rapidly and more successfully with this particular problem.

Organization of Medical Care

Now I would like to turn to a question of the organization of medical care.

I happen to be one of those who have strongly believed over the years in pre-payment and group practice. I have myself been a member of the board of directors of a group practice plan for some years—a member of a group practice plan for some 27 years. I happen to be one of those who have been quite satisfied with the quality of medical care I received from the group practice plan.

Having been on the board of directors, I know something about the problems, both from the patient's standpoint and from the doctor's standpoint, and I recognize that there are a lot of doctors and a lot of patients for whom group practice is not applicable at the present time, but I do believe that it is necessary for those who believe in group practice, and those who do not, to begin to get together and to try to resolve this great conflict that has existed about group practice. The various states which still have restrictions against the use of group practice, particularly about consumer participation, I think are both unfair and unwise, and I think in addition it is a blot upon the integrity, or upon the professional integrity, of the medical profession, to have many people believe—whether it is true or not—that organized medicine does not support or encourage or stimulate group practice plans.

Whether that is true or not we can debate for a long time, but speaking more in a public relations sense than in a substantive sense, I think it is time that we get together on this issue, and I believe it is significant that many of the younger students coming up from the medical schools today are much more in favor of group practice than probably those in this room, who are the seniors in the medical profession.

I am not trying to say that you individually, or that you collectively ought to endorse group practice, but I think for a sizable, perhaps still minority of professionals and patients, it represents a substantial area of possible adaptation to changing needs.

So, without trying to precipitate a result, I think we at least ought to open the dialogue about that, and I would hope with Dr. Egeberg's selection, this would be one of the items that would come up for discussion.

Economy of Operations

Thirdly, I think the most persistent problem that we are faced with today in medical care is from the standpoint, speaking now of perhaps the non-professional, is what I could call the interest, or renewed interest, in the efficiency and economy of operations in the medical care field.

I think that there must be a continued re-examination of new methods and new procedures to deal with problems of delivery of care. Certainly, the neighborhood health centers coming into the problems of the intercity struggle, with the problems of the ghetto — the whole fact that there are four million women, as we know from the various studies, in the fertility age group, from 15 to 44, who do not have family service plans available to them is something that certainly could be resolved.

For those of you who are concerned, John Rockefeller and I were co-chairmen on a committee for family planning last year, and we came up with a recommendation that in three years it will be possible in the United States to bring family planning services to these four million women at a relative cost of about $120 million a year, or $30 million per woman.

This is not an insuperable financial organizational question but it is one that certainly ought to be explored as another area of cooperation between the medical profession and other non-health groups in working in that area.

What I am trying to say is simply that we must not close our minds to new ways of working in the community with people outside the medical profession in the more effective organization and delivery of medical care.

The American Medical Association and various groups have expressed that health education and delivery of care is not solely a matter of concern or possible solution by the physician. Matters of malnutrition and hunger and family planning and lack of access and lack of understanding about medical care are all certainly the responsibility of other people in the community, and there must be new methods and new ways of looking at this.

I certainly agree that the whole matter of continued expansion of utilization review must continue.

There is no question on the point, it seems to me on reading the literature, that there are people in hospitals who do not need to be in hospitals. Some of them are there too long; some of them that are there do need to be there at a given moment, and certainly that indicates the need for much greater appeal of review and utilization review, and I think it also means consideration of many more alternatives to institutional care.

Certainly, our Blue Cross and our Blue Shield policies need to be radically revised and extended to be sure that home and office care are available as well as home health services and other types of services that will keep a person out of a day of hos-

pital care wherever medically indicated.

I believe one of the big problems we will see developed within these next couple of years is rather a strong revision of these Blue Shield-Blue Cross commercial policies to see that comprehensive care, including out-of-hospital, non-institutional care, is part of the method of financing this care. This certainly has been a key persistent problem, but certainly one that is now indicated on the part of the professionals and those concerned with financing as well within our capacity to resolve.

Third Party Payment

Now, the fourth persistent problem is coverage of persons and services not now covered under health insurance.

I would go back some 35 years ago when I started as a young man in this field. How controversial the whole issue of third party payment in the field of health insurance was at that time!

I think one of the great experiences of our time is the way in which the medical profession and others in the community have built into this idea of insurance third party payments that has been relatively successful as a method of dealing with one of the great problems of our time.

However, we all know that there are very substantial groups—some 20 or 25% of our population in the United States—that are not covered under health insurance of any kind whatsoever. No Blue Cross—no Blue Shield—no commercial insurance—not a single penny or dime of coverage. Others among the other 70 or 75% of the population have minimal or only inadequate coverage.

Certainly, after these 35 years, we know now that the principle is sound. We know how to make it work.

I concur in the prediction that it will not be long in the coming, in this decade, when every single person in the United States will be insured under some health insurance policy for comprehensive care.

I think the great lesson of the Medicare controversy is that if the medical profession does not cooperate, sooner or later someone else will do what is needed, without the cooperation of the medical profession.

In 1941-42, when I was working on the first legislation, I wrote a letter for one of the then important people extending an offer to the American Medical Association to cooperate in the advice on the first health insurance bill. That was turned down.

In 1961, when I first came in as President Kennedy's Assistant Secretary, I wrote a letter for one of the secretaries, offering the American Medical Association the opportunity to comment on the various provisions of what was then the King-Andersen Bill, and eventually became the Medicare Bill. The opportunity was not accepted.

I think that was too bad. I think many of our problems in Medicare and Medicaid go back to that failure on the part of the medical profession not to have had an opportunity for consultation and participation.

Where the participation in the Medicare program after 1965 was substantial, as we offered it in 1965, there has been relatively good success. Where there has been lack of cooperation and understanding, the program has had certain failings.

And so I believe it will not be long, and I would predict by 1976 in this country, that every single one of the then 220 million people in this country will be covered under a comprehensive health insurance policy. The only question is how.

Now, I think in this next year we can find the formula to work together. First, I believe very strongly that the disabled ought to be covered under the Medicare program.

There are about one and a half million people under the age of 65 already drawing Social Security benefits who are exactly in the same situation as those over 65, and they ought to be brought into the Medicare program, just like senior citizens 65 or over.

Over half of any kind of voluntary health insurance policy holders—and most of them about six or eight months or a year after they are disabled—lose those policies because they are not able financially to keep up their private insurance.

I think it would be a boon to private insurance as well as to individuals to have them covered under Medicare, and I see no radical departure in the extension of that principle by covering people who are old among the group, who are old by chronological age, and I would hope that rather than opposing that feature when Congress begins to consider it this fall and next year, that the medical profession will show statesmanship in supporting it rather than opposing it.

I think this will be one of the first steps in the development of a cooperative relationship and working out the developments of that so that its administration would be successful.

Prescriptions Should Be Included

I believe that the coverage of prescription drugs under the Medicare program is also essential. I should say quite frankly that I view it with some hesitancy because the problem of the administration of a whole series of prescriptions which are in the millions is a very, very big administrative problem. I think our computers are not completely equipped yet to deal with this problem.

I would begin in a very limited way, taking only the most high cost long continuing drugs and not start in a comprehensive way, but for most of our senior citizens, who are living on rather small incomes, and particularly the four percent who

have prescription drug bills of over $250 a year—I think we should insure those costs of prescription drugs under the Medicare program.

As I said to the drug businesses, the drug companies—as I have said to the pharmacists, and as I would say to you, the time to get into talking about the specifications and the administration of that is in the beginning rather than after it is the law of the land because certainly, as I stand before you, and whether you are for it or against it, I would predict that sooner or later it would be the law of the land.

Prenatal Care Program

It is a rather difficult thing in the United States to realize that we are only 14 or 15 in the world in our rate of infant mortality; that is, there are 14 or 15 other countries which have a lower infant mortality rate than we have.

Right here in New York there are places where the infant mortality rate is as high as 35 or 50 for every thousand live births, and others where it is as low as 15; there are others where it is as low as ten, and there are places in Intercity Chicago where they are as high as 40%.

We also happen to know that out of the 3½ million women who deliver a child each year, there are somewhere in the neighborhood of about five, six, or seven hundred thousand by sample studies that do not have comprehensive prenatal care at the present time. Most of these women, of course, are women in the low income groups, among the black members of our society, among the Appalachians, among those with low educational attainment, with little health education, but the fact is they still produce 5, 6, 700,000 children a year, and without comprehensive prenatal, and possibly even postnatal care.

I believe that part of the infant mortality, part of the maternal mortality, part of the lack of good access to the delivery of health care would be met if we were to develop a comprehensive prenatal care program.

But a Kiddie Care program, whether that should be handled through an insurance mechanism or through the prenatal and child health care program, is one of the questions on which the cooperation of the medical profession could be effective and meaningful if a new dialogue and a new discussion were to develop.

As I said, I believe that health insurance will be extended during the coming decade to all these millions who don't have it today, and on a policy or on a basis that will assure a rather comprehensive policy, including both hospital care and an incentive on keeping people out of high cost institutional care.

As a matter of fact, I think that if everybody is covered, we might even include in that kind of a program giving every physician in the country a minimal malpractice insurance coverage.

I think, as a matter of fact, that if we could sit down in a room and discuss how that could all be worked out, you would find there were many advantages to the profession.

However, whether it is done by asking people to sign up under Blue Cross or Blue Shield or commercial insurance, or Medicare, in my mind remains one of the big open questions of our time, and again, I say now is the time for the health professions and others to sit down and explore that question, because if it is not explored, it still is going to be answered sooner or later.

We Must Cooperate

Fifth, one of the big persistent problems in my opinion is cooperation between public groups or consumers and the professions.

As I see the problem, looking back to 1938 when the first Wagner Bills were introduced—that is a good sort of marking point—there was a period of time in 1938 when the American Medical Association and medical groups evidenced an interest in cooperation with consumers and government.

By 1939 that had broken, and roughly you might say that from 1940 to 1965, some 25 years, there was a complete separation, because there wasn't a really effective opportunity for dialogue and exchange of views.

It is my opinion that with the passage of Medicare and Medicaid, an opportunity for an era of dialogue and constructive communication is now possible. The appointment of groups like "Help Back the Health Insurance Committee," with representatives on it from a host of other bodies, advisers from Medicare, and so on and so forth, that now enable us to communicate, there ought to be more effective dialogue, but I believe it does mean that there has to be this common understanding, which I think has been most difficult, and that is that consumers of medical care have a right to express their views and their concern about the quality of medical care, the method of financing, and the method of organization.

It is not possible, ladies and gentlemen, for 300,000 physicians in this country, with 200 million population, to completely determine all of the terms and conditions that go into the complex question of medical care, medical schools, medical education and delivery of care, access to care and Blue Cross and Blue Shield and Medicare.

I think the whole 200 million, including the 300,000 physicians and 650,000 nurses—in fact, all three million of the people working in the health industries, have to be brought together in a new kind of working relationship. I believe that one of the most important suggestions that I can make is that the health professions and the physicians

generally seek out consumers of medical care and attempt to work with them in some kind of a cooperative relationship.

I would recommend that in every county medical society, every state medical society, there be set up a joint consumer medical committee to deal with these new and—I shouldn't say "new"—but with the current problems of pricing and costs and relationships with the medical profession.

There is no question in my mind that prices and costs in medical care are going to continue to rise. You and I can look upon that with some degree of criticism, or some degree of unwillingness, but the fact of the matter is if you look at the next ten years of hospital costs, if you look at matters relating to equipment, if you look at the demand for medical care, there is no other way but for the total expenditures in this country for medical care to go up, and in my opinion they will probably go up something in the nature of about five billion dollars a year.

We are spending 55 billion dollars a year now for all aspects of health costs in this country, and by that I mean Blue Cross, Blue Shield, out-of-pocket payments to doctors and hospitals, the construction of hospitals, and other facilities, and nursing homes, and medical education.

If you take the whole ball of wax of what you and I and every one of the 200 million people in this country paid, it is 55 billion dollars, a little over six percent of the gross national product, and it is going up in dollars, in percents, and faster than probably other items in the general cost of living index.

So it behooves all of us, whether you are a physician, whether you are a nurse, whether you are an economist, whether you are a consumer, whether you are a politician—for the consumer, and the politician, and the physician, to begin to get together.

I don't think this thing can be solved by the consumer unilaterally or the physician unilaterally, and it can't be solved by the politicians unilaterally. If there is some way we can find a mechanism that every one of the three thousand counties in every one of the 50 states, that consumers and physicians in other medical groups were to work together, continually study and bring in information to the public on what is happening on demand, on cost, doing a kind of self-policing, and showing the responsibility that is involved, I think it could well change the situation.

For instance, let me give you just an illustration in the Medicaid problem. In the administration of the Medicaid program, most of the state agencies that administer that program are state welfare agencies—not state health agencies.

Why is this? Because the state health agencies have not in the past been particularly consumer-oriented, because in the past it has been an adaptation of the welfare program, and because the welfare agencies, whatever else their failings were, and whatever else their non-relationships to the medical profession are, at least sought out other people in the community who paid the tax bill, who were concerned about access and delivery of medical care.

I myself favored the transfer of the responsibility of administering the Medicaid program to the state health departments from the state welfare departments, but it is not possible in many states until there is a major reorganization and reorientation of the role of the state health department and its relationship to people outside of the health industry and to the effective consumer participation, where tax funds are being paid. I believe that this is certainly an area of concern.

A Time of Upheaval

Let me say in closing, there are lots of changes going on in our society at the present time. The changes that are occurring are not merely changes in medical care but, if you sat down yourselves and put down a list and said what is happening in our total society, I am sure many things happening are distressing to you, as they are to me, but it is clear to me that vast changes are under way.

The whole presence of the Peace Corps and Vista and the Teacher Corps, in affecting idealism and experience of young people in recent years, is a significant thing.

I don't need to tell you about the vast effect that student participation in colleges is having, and I predict we will have significant changes in medical schools as well during this coming decade, so that when you gentlemen go back to your medical schools, five or six years from now, you will see a vastly different student body than when you went to school, with vastly different attitudes on the part of the young people coming into medical school, and certainly freshman classes doubled in medical schools.

You will find more black people in the medical schools—more women. You will find more people with different social attitudes than those of us who came up in education in the thirties, forties and fifties.

Let me say I just finished making a study of student participation in high school, and I met with a group of people who were telling me what kind of student unrest is going on in the elementary school, which was rather devastating to me.

All I want to say is there is a lot of change in attitude coming up. Don't think that those who talk about changes in medical care are just picking on the medical profession. They are not. It is pervasive throughout our society.

You look at the black militancy that is occurring, and when you see collective bargaining about teachers in the profession, and when you see the movement of people out of

cities and into the suburbs, when you see industries moving into the South, changing the kinds of relationships there, when you see the kinds of political realignments going on in this country, where old conventional attitudes about conservatism and liberalism are changing, when you see Republican, Democrat or Independent—what this is going to be doing in the next eight years in our body politic—I only say to you that these tremendous social changes that are going on are not merely limited to the United States of America, must inevitably have equally an impact upon physicians and on medical care.

Seven years from now, I think I am right, is the 200th anniversary of the Declaration of Independence of the United States, in 1976. I think when 1976 comes you are going to see a vastly different America from the one that was 1876, 1926 or 1956.

I might say that it is only about ten years since Sputnik came about, and in my opinion, when you look back and try to trace some of these changes, the appearance of the Russian Sputnik was one of the most intensive factors in changing our lives.

Why? Because it showed that the United States of America no longer had the exclusive scientific leadership in the world, that other countries were able to compete with us.

If we in the United States want to retain our leadership, as I hope we shall, retain our freedom and our independence, a new era of constructive dialogue, constructive working together, must occur.

And as one who was Secretary of Health and Welfare in the last administration, I hope all of you will give constructive aid to Secretary Finch and to Dr. Egeberg in the development of health policies.

I regret that it has taken six or seven months to appoint a new assistant secretary of health. Twenty billion dollars in health affairs have been spent during that time while there was no leader in our nation's capital in this area. We have got to make up for lost time.

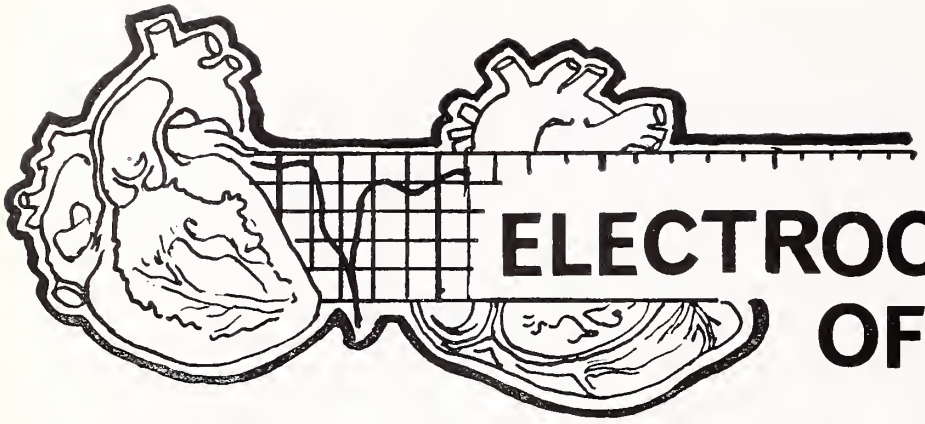
It is extremely important that under Dr. Egeberg and Secretary Finch's leadership we explore every possible way to develop a new type of cooperation, a new era of good feelings and an opportunity for the exploration of any idea, no matter how controversial, no matter how debatable, so that we can still have a system of medical care on the one hand that uses the talents and the abilities of free men and free women but at the same time accomplishes that objective which I think has always been the objective of the medical profession, which is that every man or woman who needs medical care will get the highest quality of medical care without regard to race, without regard to religion, and without regard to income at the time that they need that medical care. ◄

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ELECTROCARDIOGRAM OF THE MONTH

Pacemaker Electrocardiography (IV)

*CHARLES FISCH, M.D.**
Indianapolis

THE basic rhythm is sinus with a second degree A-V block (3:2) of the unusual or Mobitz II variety. The more common form of A-V block is the Wenckebach type (Mobitz I) in which there is a gradual prolongation of the P-R interval before the dropped beat. In Mobitz II the dropped beat occurs unexpectedly without any prior prolongation of the P-R interval. This type of block is usually peripheral (e.g., involves the bundles rather than the bundle of His) and very often results in complete heart block and Adams-Stokes disease. For this reason it is important to recognize this type of conduction defect and treat it with a pacemaker.

Regularly spaced stimulus artifact is seen which is in no way affected by the spontaneous ventricular activity *(fixed rate pacemaker)*. Only the first of the six stimuli results in a ventricular complex. The remaining five fall during the refractory period of the normally conducted impulses and fail to elicit a response. As was pointed out earlier, fixed rate pacemakers are now rarely used. ◄

* From the Krannert Institute of Cardiology, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.

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V5

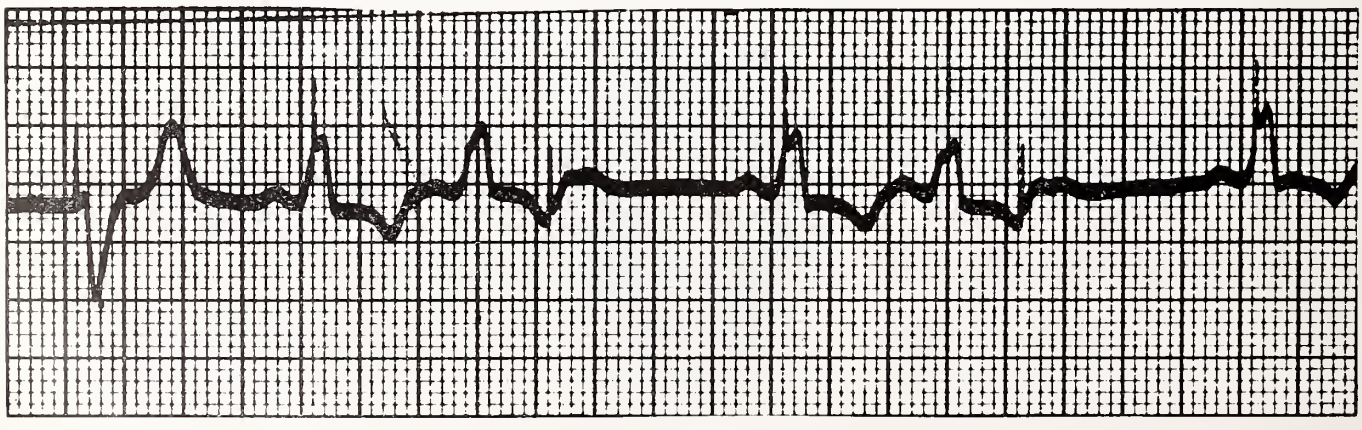


FIGURE 1
SINUS rhythm with a 3:2 Mobitz type II A-V block with a fixed rate pacemaker.

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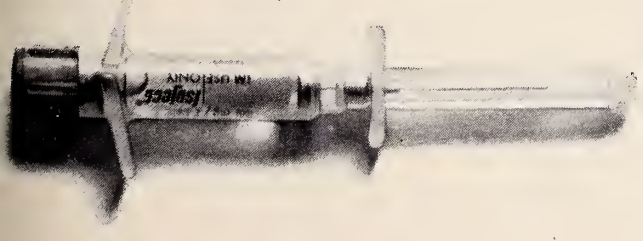
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oxytetracycline)

Fire victim. Examination reveals second degree burn of lower leg. To combat shock, restore circulatory volume and replace protein loss, plasma is administered. Local pressure dressing applied. Limb elevated to limit the flow of lymph. About 36 hours after admission the patient develops an elevated temperature and complains of pain at the site of the lesion. Dressing removed. A suppurating slough area has developed over part of the burn. A swab specimen is taken for culture and the slough area is debrided. Antibacterial treatment is begun with Terramycin I.M. Days later, recovery is progressing, and the laboratory report shows a mixed infection with a predominance of susceptible coliform bacteria, confirming the therapeutic choice. Terramycin therapy is continued until all signs of infection disappear.

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Contraindicated: In individuals hypersensitive to any of the components of this drug.

Warnings: If renal impairment exists, even usual doses may lead to excessive systemic accumulation and possible liver toxicity. In such patients, lower than usual doses are indicated and for prolonged therapy oxytetracycline serum level determinations may be advisable.

Terramycin may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight. Discontinue therapy at first evidence of skin discomfort.

Note: With oxytetracycline, phototoxicity is not believed to occur and photoallergy is very rare.

Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy.

As with all intramuscular preparations, Terramycin Intramuscular Solution should be injected well within the body of a relatively large muscle. *Adults:* The preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. *Children:* It is recommended that intramuscular injections be given preferably in the mid-lateral muscles of the thigh. In infants and small children the periphery of the upper outer quadrant of the gluteal region should be used only when necessary, such as in burn patients, in order to minimize the possibility of damage to the sciatic nerve.

The deltoid area should be used only if well developed such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Increased intracranial pressure with bulging fontanelles has been observed occasionally in infants receiving therapeutic doses of the drug, but such signs and symptoms have disappeared rapidly on cessation of treatment with no sequelae.

Adverse Reactions: Subcutaneous and fat-layer injection may produce mild pain and induration which may be relieved by an ice pack. Very mild gastrointestinal disturbances, not requiring discontinuance of the drug, may occur occasionally. Allergic reactions, including anaphylaxis, rarely have been observed.

Dosage: *Adult:* The optimal dosage varies, depending on the type and severity of infection. Unless otherwise specified, a dose of 100 mg. every 8 to 12 hours, or a single daily dose of 250 mg. should be adequate for the treatment of most mild or moderately severe infections. In severe infections, 100 mg. every 6 to 8 hours, or 250 mg. every 12 hours may be necessary.

Serum levels obtained by the recommended dosages are comparable to those provided by the oral dosage of 1 to 2 Gm. daily in adults. Antibiotic therapy should be continued for at least 24 to 48 hours after all symptoms and fever have subsided.

In certain diseases specific courses of therapy may be recommended as a general guide. In primary and secondary syphilis for example, the daily administration of 2 Gm. oxytetracycline, orally, in divided doses for two weeks has given good results. In cases of gonococcal infection two intramuscular injections of 250 mg. each, or one intramuscular injection of 250 mg. combined with one gram given orally as a single dose, will usually suffice, but repetition of this therapy will be required in an occasional case.

In the treatment of hemolytic streptococcal infections, therapy should continue for at least 10 days to prevent development of rheumatic fever or glomerulonephritis.

In the treatment of staphylococcal infections indicated surgical procedures should be carried out in all cases.

Pediatric: A dosage of 3 mg./lb./day in two doses has been found satisfactory in the treatment of most mild to moderately severe infections. For more severe infections, higher dosages may be indicated and should be adjusted accordingly.

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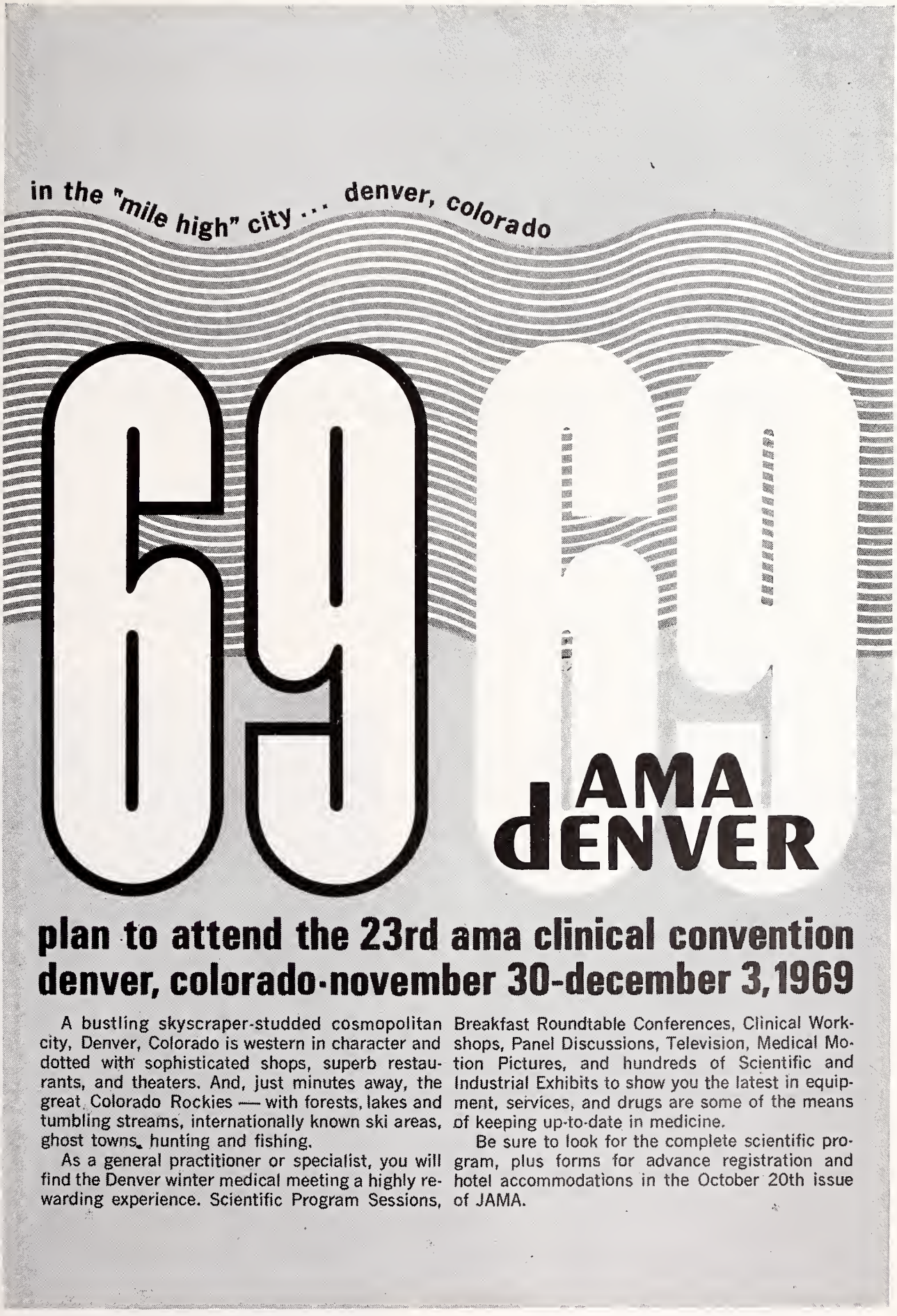
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X-RAY CONFERENCE

Arteriographic Assessment of Viability of Bowel After Perforating Abdominal Injury

*ERICH K. LANG, M.D.**
Shreveport, La.

THIS 22-year-old colored male was admitted for a perforating abdominal injury sustained some four hours earlier. At the time of admission, the patient was in shock. An entry wound was seen in the right mid-abdominal field. A flat plate and upright of the abdomen failed to show free air below the diaphragm. An emergency intravenous pyelogram showed prompt function of both kidneys, however slight lateral displacement of the upper pole of the right kidney was noted suggesting a retroperitoneal hematoma. A metallic foreign body (projectile) appeared to be lodged at the level of L1-L2 in the retroperitoneal space. Traumatic injury of the inferior vena cava was suspected.

The patient was explored and a large retroperitoneal hematoma was evacuated. There was no direct injury to the inferior vena cava, however several lumbar veins appeared to have been severed, causing the retroperitoneal hematoma.

There was no evidence of direct injury of bowel loops although a large hematoma was found in the mesentery of the right colon. Conservative management was instituted. The patient's condition remained



FIGURE 1

A SELECTIVE superior mesenteric arteriogram demonstrates filling of all major branches of the superior mesenteric group. Note the splaying of a branch of the right colic artery (arrows). The displacement is caused by a hematoma in the mesentery. Perpendicular arcade vessels, however, fill in the questioned area and ascertain viability of the arterial supply of this loop. Late phase roentgenograms failed to show any abnormal stain pattern; venous thrombosis was excluded on the basis of this observation.

* Professor and Chairman, Department of Radiology, Louisiana State University School of Medicine in Shreveport, Shreveport, La. 71106.

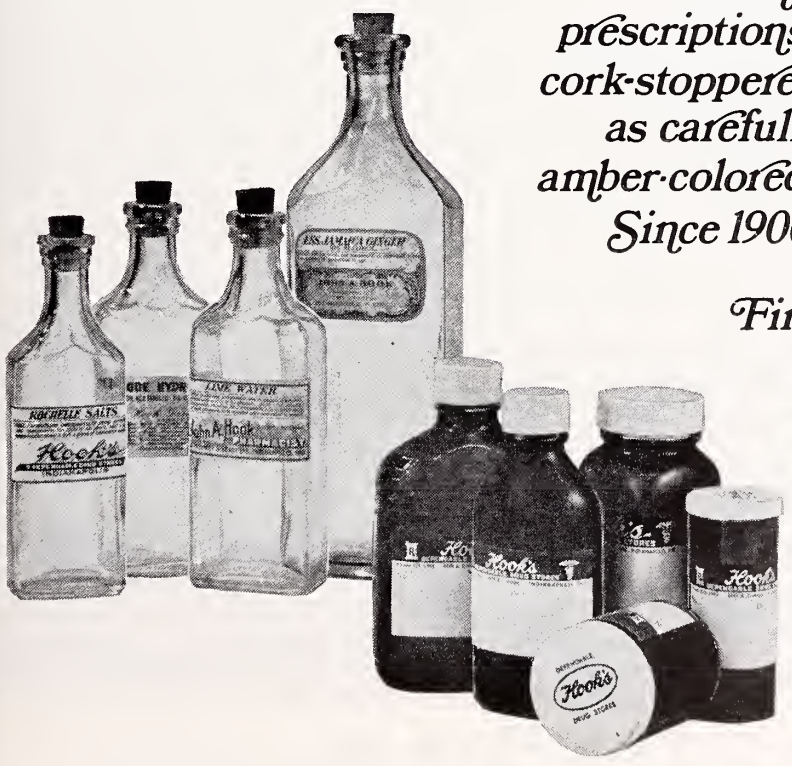
guarded and possible necrosis of a segment of the right colon secondary to the traumatic injury and ligation of some bleeding branch arteries at the time of exploration was questioned.

A selective superior mesenteric arteriogram was performed on the seventh postoperative day (Figure 1). There was prompt visualization of the right colic artery and apart from splaying of one of its major branches, undoubtedly secondary to re-accumulation of hematoma in the mesentery, no significant abnormalities were noted. The perpendicular arcade branches filled in the questioned segment suggesting viability of the bowel. Delayed phase roentgenograms failed to show a sustained stain suggestive of venous thrombosis. On the basis of this examination, continuation of conservative management was decided. The patient had a rapid recovery in his second postoperative week and was discharged on the 17th postoperative day.

Comment

Selective mesenteric arteriography is a valuable procedure for the assessment of viability of bowel loops subjected to blunt or penetrating trauma. The method is recommended to ascertain the adequacy of vascular supply to a given area. On basis of splaying and displacement of the vessels, the presence of hematomas in the mesentery or in the wall of the bowel itself can be ascertained.

The procedure is innocuous and can be performed on patients under all conditions—even when in surgical shock. The rapidity and relative ease recommend this procedure for widespread pre-exploratory use to afford the surgeon accurate preoperative diagnosis and guidance in the decision of resection of injured bowel. The method, however, is also useful as follow-up examinations for continued assessment of viability of injured bowel loops. ◄



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From *The Journal* 50 Years Ago

In the past the basis of treatment of surgical joints has been in practically all conditions immobilization, hot applications and later passive motion and massage. These principles have been dogmatic. The end results have not always been the best, for in purulent infections of the joints the surgeon could forsee only loss of motion in the joint, amputation of the extremity or death of the patient, while the intra-auricular fractures always had the possibilities of a partial or complete ankylosis. The opening of a joint was undertaken with a dread, not of the surgical difficulties but of the possible infection with its tragic end result.

The key note of Willems treatment of joint conditions is immediate, continuous, active mobilization. This phrase can be translated in an absolutely literal sense. By immediate mobilization is meant that the joint shall be moved as soon as the patient has awaked from the anesthesia. By continuous mobilization is meant that the joint shall be moved as often through the day as the power of the muscles will permit (and even in the night the patient may be awakened to take his exercise). By active mobilization is meant that all motions must be made by the muscles controlling the movements of that particular joint; that neither the surgeon nor the nurse nor the patient shall in any way give passive motion. What a swing of the pendulum from the teachings of long rest in splints and plaster casts, of passive motions and massage and of prolonged baking and hot applications! . . . . E. B. Mumford, M.D., Indianapolis, "Active Mobilization in Joint Conditions," *JISMA*, November, 1919.

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Devoted to the interests of the medical profession of Indiana

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Indiana Medical Foundation

A foundation for charitable, educational, and scientific purposes has been formed by the Indiana State Medical Association.

Incorporation of The Indiana Medical Foundation was accomplished on July 26, 1968, after the Board of Trustees of the association had authorized its formation. The form and purposes of the tax-exempt endowment had been under study for several years prior to this.

Notice has been received from the Internal Revenue Service that the Foundation is recognized by the Service as being exempt from federal income taxes. In addition, contributions made to the Foundation are deductible by donors in accordance with the Internal Revenue Code.

Bequests, legacies, devises, transfers or gifts to the Foundation or for its use are deductible for Federal estate and gift tax purposes.

The Foundation was originally suggested to provide an endowment fund to support the educational mission of the association and *The Journal*.

Postgraduate and continuing education has become increasingly important in medicine and presumably will become more so in the future. It is fitting that a program of this nature be supported by an endowment composed of the gifts, bequests, and memorial contributions of members of the association and the friends of the medical profession.

Guest Editorials

Inflation is a Leaky Bucket

THERE was once a waterboy for a road construction crew who had a leaky bucket, and it was a long way from the water wagon to the job. So the boy complained. The boss wasn't interested in fixing the bucket, but he had an angle.

"We're not going to let you run dry," he said. "We have a little water stashed along the way and every so often you can stop and put in a dipperful."

So the boy went off with the bucket, although the leak kept increasing.

One day the boss said, "These stashes of water are getting low. Every time you put in a dipperful you'll have to take out a half dipperful and put it back in the stash. That way any problems we might have will be postponed."

Then the boy began arriving with half a bucketful and the men began to complain.

The boss said to the boy, "You've been cheating on the stashes. Your citizenship and social responsibility are all wrong. From now on, every stash gets a dipperful out of your bucket."

Now when the boy got to the men, the bucket was empty. The men cursed him.

The boy said, "To hell with carrying water." He threw down the bucket and ran away. That was when the strike started.

Inflation is a leaky bucket. Those who carry the liquid assets of cash will sadly watch the value leak away. Interest on savings or bonds is a way of replenishing the bucket from the stashes.

But where the leak outbalances the input from the stashes, and where this imbalance is intensified by requiring that part or all of the dipperful be returned, the enthusiasm goes out of water-carrying.

At four percent annual inflation a man holding a four percent savings account gets nothing minus the income tax he pays on his interest.

Pretty soon the bucket will be getting awfully empty. So the carrier will go off to play the stock market or buy diamonds or real estate or German marks.

Then the road jobs will begin to fold up.—**Jenkin Lloyd Jones,**

President, Chamber of Commerce of the United States, Washington, D.C.

Editorial Notes . . .

Upjohn has developed a chemical which, with one dose, leaves male rats healthy, energetic, aggressive—and permanently sterile. Further work is necessary before it can be released. So far, it is determined that the chemical is relatively nontoxic to other species including man. It produces only temporary sterility in the guinea pig, ram, and monkey, and has no effect on mice and rabbits. The big idea is that the aggressive sterile rats will keep the females so busy the potent rats won't have a chance.

Continuing investigation of side effects and possibly mortality which may accrue to users of oral contraceptives appears to indicate that users risk 4.4 times the death rate of non-users. However, this rate is well below the death rate of childbirth which is some 17 times as high.

Family Practice is welcomed by Cortez F. Enloe, Jr., M.D., editor of "Nutrition Today", in the first paragraph of his editorial as follows: "The AMA announcement that Family Practice will be elevated to a medical specialty is welcome news. It means the doctor who treats the whole person is now to be considered just as important as the physician who treats only a part of a person. Hopefully, this event will remind everyone connected with medical care that no matter his specialty, his first concern must be for the individual. If this message is taken to heart, all medical practice will be enriched."

Emergency Animal Relief of the American Humane Association accepted a challenging job when Hurricane Camille struck the Gulf Coast. Both pets and domestic animals were imperiled by the destruction. There were about 6,500 dogs separated from their homes and masters, as well as thousands of farm animals without food or attention. In the first week over 100 tons of animal food was made available. In some flooded areas food was dropped by air to stranded livestock. Pet food from as far away as Chattanooga was rushed to the scene.

Vaccine against rubella (German Measles) is now available to prevent the fetal abnormalities which often develop when the disease affects women in the first or second trimester of pregnancy, and to prevent the serious complications when the disease occurs in postpubertal patients. Pregnant women must not be given the vaccine since the resulting viremia may cause the same fetal calamities the active disease does. Recommendations are that children under ten should all receive the vaccine. History of rubella is not reliable enough to forego the vaccination. Since the product is new and does not have much of a clinical history, all untoward reactions should be reported to the Indiana State Board of Health.

Antilymphocyte serum (ALS) contains two specialized inhibitors, one for graft rejection and one for inflammation. Researchers at Upjohn report that they have been able to separate the two inhibitors. When ALS is produced by immunizing horses against rat lymphocytes, the skin graft protecting factor was obtained at three weeks, the anti-inflammatory portion appeared after six weeks and the serum at that stage did not have any graft protecting ability.

Tissue cultures are often the best media for growing viruses. The use of progressive cell cultures for the production of virus vaccines has been viewed with caution because of the supposed possibility of creating neoplastic cell change which might be transmitted to a patient who received the vaccine. Researchers at Eli Lilly, however, have produced three different vaccines from viruses grown in highly malignant cells and have administered the vaccines to susceptible animals without transmitting the cancer.

The Food and Drug Administration has proposed changes of investigational new drug regulations which would require the establishment of "peer group committees" in all institutions testing new drugs on human subjects. The object is to improve the quality of experimental results and provide added protection for human volunteers taking part in the new drug tests. Committee members would be chosen by the research institution. ◄



The Woman's Auxiliary

REPORTS TO ISMA

Fall represents, in most of our minds, and certainly in the normal course of the four seasons— the time of harvest—of reaping. It is the spring of the year that witnesses the plowing and harrowing—the planting of the seeds.



In Indiana medical auxiliary work, we turn the seasons around. The fall is our plowing time, our planting time. The spring is our time of harvest.

The state officers and chairmen have just completed their tour attending the fall workshops held in Evansville, Indianapolis, and Fort Wayne. The workshop is springtime in reverse. It was the time for state chairmen to plant ideas and suggest the best ways of nurturing them. It was the time for person-to-person assistance and discussion. The state chairmen can function so much better when they know the county chairmen. There are innumerable ideas to be promoted—cooperation to be achieved and results to be sighted.

In order to reap a harvest next spring, county auxiliaries must be knowledgeable about the broad spectrum of auxiliary activities. From AMA-ERF to health careers, from health education to safety and mental health—from children and youth to legislation—from membership to communication.

That's what our fall workshops were all about. It was also a time for discussion, for exchange of ideas, for re-evaluation. And a wonderful time for togetherness!

Sylvia Schneider



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There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

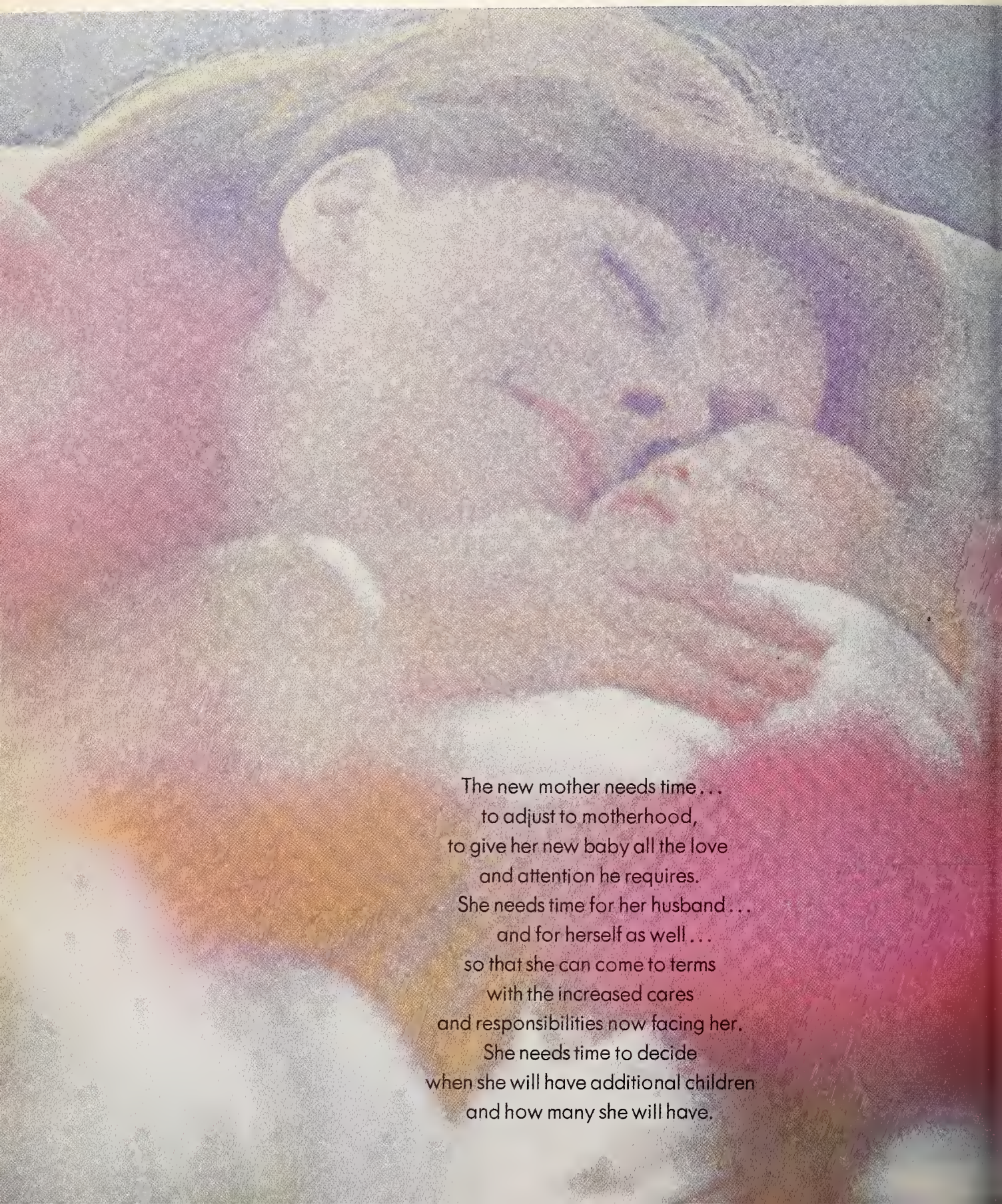
Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



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The new mother needs time . . .
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to give her new baby all the love
and attention he requires.
She needs time for her husband . . .
and for herself as well . . .
so that she can come to terms
with the increased cares
and responsibilities now facing her.
She needs time to decide
when she will have additional children
and how many she will have.

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Your prescription for Ovulen-21 gives the new mother time to meet her family's present needs...to plan for her family's future.

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Immediately post partum is the time

It is the time when motivation is highest—when a new mother needs expert advice for the future, so she can space her children and limit her family.

It is also the most opportune time, since she is conveniently present in the hospital, for her to be given both instructions and a prescription.

Non-nursing mothers may begin Ovulen-21 immediately after delivery, on the day of departure from the hospital or at the first postpartum visit, as desired. It is recommended that nursing mothers begin Ovulen-21 four weeks after delivery.

A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Indication—Oral contraceptian.

Contraindications—Thrombaphlebitis, thramboembolic disorders, cerebral opoplexy ar a post history of these conditions, markedly impaired liver functian, knawn ar suspected carcinama of the breast, knawn or suspected estragen-dependent neoplasia, undiagnosed obnormal genital bleeding.

Warnings—Watch far the earliest manifestatians af thrambatic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrambasis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- ta tenfald increase in mortality and marbidity due to thrambaembolic diseases in wamen taking oral contraceptives. In these cantrolled retrospective studies, invalving 36 reparted deaths and 58 haspitalizatians due ta "idiapathic" thrambaembalism, statisticol evaluatian indicated that the differences observed between users and nan-users were highly significant. The canclusians reached in the studies are summarized in the table belaw:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Categary	Martality Rates		Hospitalizatian Rates (Marbidity)
	Age 20-34	Age 35-44	Age 20-44
Users af Oral Cantraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

Na camparable studies are yet availoble in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannat be applied directly to women in ather cauntries in which the incidences af spantaneously occurring thromboembalic disease may differ.

Discontinue medicatian pending examinatian if there is sudden partial ar camplete loss af visian, ar sudden onset of proptosis, diplapia or migraine. Withdraw medicatian if papilledema or retinal vasculor lesians are faund.

Since the safety af Ovulen in pregnancy has not been demanstrated, it is recommended that pregnancy be ruled out far any patient who has missed two cansecutive periads befare continuing the contraceptive regimen. If the patient has nat adhered ta the prescribed schedule the passibility of pregnancy should be considered at the first missed period.

A small fractian af the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Precautions—Pretreatment physicol examinatian should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefare, it is recammended that such tests if abnormal be repeated after the drug has been withdrawn far two months.

Pre-existing uterine fibromyomas may increase in size under the influence af progestagen-estrogen preparations.

Because these agents may cause some degree of fluid retentian, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nanfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depressian and discantinue the drug if severe depression recurs.

Any passible influence af prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose talerance has occurred in a significant percentage af patients an oral contraceptives. The mechanism of this decrease is obscure. Far this reason, diabetic patients shauld be abserved carefully while receiving Ovulen.

Because af the effects of estrogens on epiphyseal closure Ovulen shauld be used judiciously in young patients in whom bone growth is nat complete.

The age af the patient constitutes na absalute limiting factor, although Ovulen therapy may mask the onset af the climacteric.

The patholagist shauld be informed af Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant assaciatian has been shown between use of oral contraceptives and the following seriaus adverse reactians: thrombophlebitis, pulmanory embolism.

Although available evidence is suggestive of an association, such a relatianship has been neither confirmed nor refuted far the following seriaus adverse reactians: cerebrovasculor accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The fallawing adverse reactians are known ta accur in patients receiving aral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdaminal cramps and bloating), breakthraugh bleeding, spatting, change in menstrual flow, amenorrhea during and after treatment, edema, chlaasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretians, suppressian of lactation when given immediately post partum, chalestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Althaugh the fallawing adverse reactians have been reported in users af aral cantraceptives, an associatian has been neither canfirmed nor refuted: anavulation past treatment, premenstrual-like syndrame, changes in libida, changes in appetite, cystitis-like syndrame, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multifarme and nodosum, hemorrhagic eruption, itching. The following laboratory results may be altered by oral cantraceptives: hepatic function: increased sulfabramophthalein and ather tests; caagulatian tests: increase in prothrombin, Factors VII, VIII, IX and X; thyraid function: increase in PBI and butanal extractable pratein bound iadine, and decrease in T^3 uptake values; metyropane test; pregnanedial determinatian.



References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see complete prescribing information.

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LOWELL H. STEEN, M.D.

President

Indiana State Medical Association

1969-70

Dr. Lowell H. Steen of Hammond succeeded to the presidency of the Indiana State Medical Association during the annual convention in October.

Dr. Steen has always been very active in all the affairs of organized medicine. His year as president-elect climaxed his service as chairman of the Board of Trustees, of which he was a member for six years. His participation in the work of his county, district, and state medical organizations and his own specialty societies is legendary.

He is a native of Kenosha, Wisconsin and earned the B.S. degree from Indiana University in 1945 and his M.D. degree from Indiana in 1948. He interned at Mercy Hospital in Chicago and was resident in internal medicine at the Hines VA Hospital. He spent a year as senior resident at Hines in the specialty of gastroenterology.

Dr. Steen had his original military service as Surgeon of the 25th Division Artillery in 1949 and 1950. Later, in 1955 and 1956, he was Chief of the Medical Service of the U. S. Army Hospital at Salzburg, Austria.

He started in private practice with The Whiting Clinic in 1953, and from 1965-1969 was chairman of the Clinic's Department of Internal Medicine. From 1964 to 1969 he has been a member of the Executive Committee of the Clinic. He is also Clinical Instructor, Stritch School of Medicine of Loyola University.

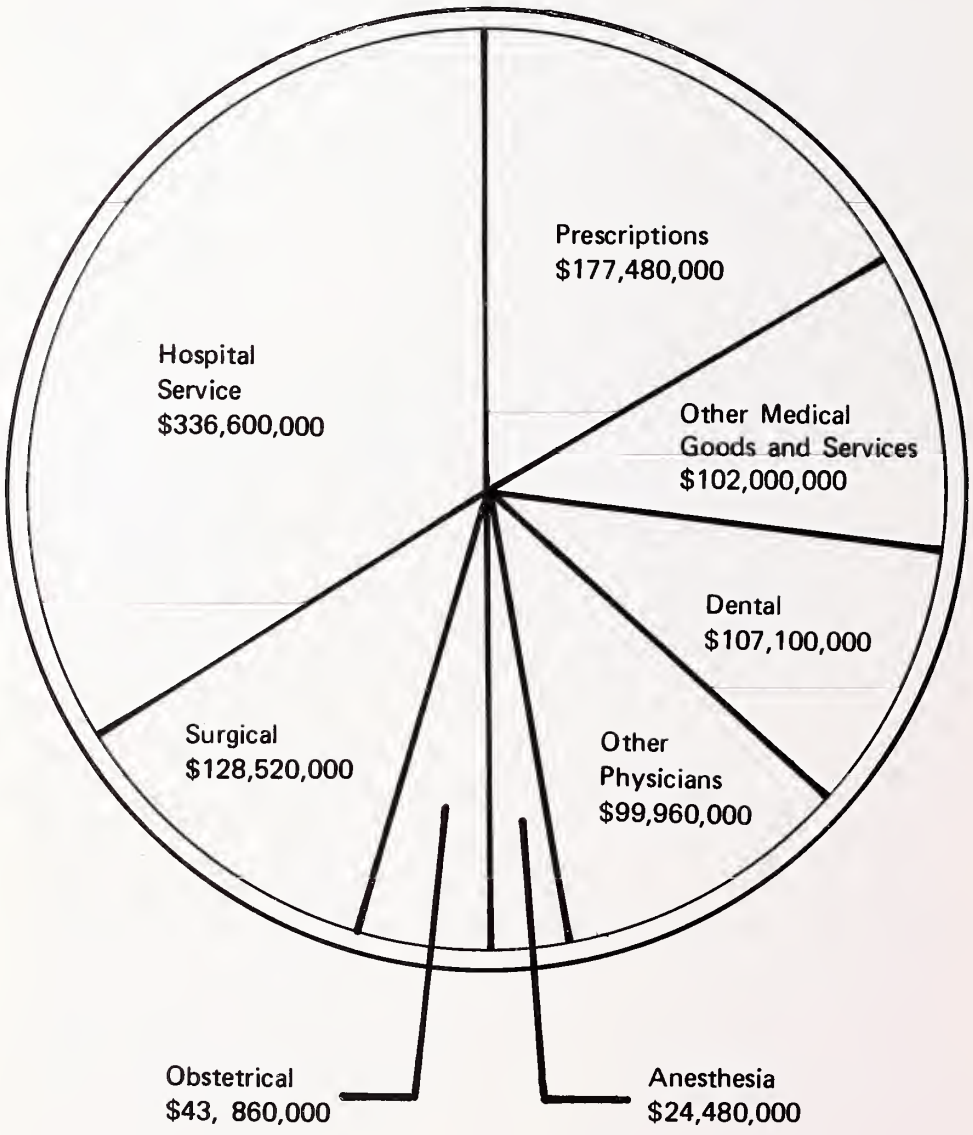
Dr. Steen is a Fellow of the American College of Physicians. He is a member of the American Heart Association, the American Geriatric Society, the American Rheumatism Society, the American Society of Internal Medicine and its Indiana chapter, of which he was president in 1962, and the American Association of Medical Clinics, for which group he occupies many committee appointments.

He was Director of Medical Education of St. Catherine's Hospital in East Chicago. Besides his interest in education he has been concerned in various medical organizations with the subjects of hospital utilization, prepaid medical care plans, patient grievance, health care for migrant workers, and medical care problems of labor organizations. He is also a gubernatorial appointee to the Health Facilities Council of the Indiana State Board of Health.

Indiana's Health Care Bill In 1968

$1,020,000,000

(One of a series prepared by Blue Shield)



Source: U. S. Statistical Abstract and Blue Cross and Blue Shield Financial records.

The total dollar volume on the above chart indicates that health care has become one of Indiana's largest "industries." It is also a growing "industry," since the total amount has almost doubled in the past four years. Nationally health care accounts for about six percent of the gross national product, and current predictions are that by 1975 health care's share of the gross national product may reach seven percent.

The role Indiana Blue Shield is playing in financing the medical service portions of the total health care bill will be shown in graphic form in later issues of *The Journal of the Indiana State Medical Association.* ◄



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*Avoids constipation.

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See next page for prescribing information ▶

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Indiana Regional Medical Program

GEORGE F. LEAMNSON*
Indianapolis

THE Indiana State Medical Association's Board of Trustees has endorsed the concept of regional medical programs in Indiana.

The action was taken at the Board's June 29, 1969, meeting by passage of a resolution which also encouraged medical association member physicians "to support the objectives and plans of the Indiana Regional Medical Program and to help determine ways in which they and agencies and institutions with which they are affiliated might become involved in this broadening regional cooperative arrangement."

(The full text of the resolution is reproduced at the end of this article.)

Indiana Regional Medical Program now is well into its third year of formal existence. But even before it received a federal planning grant, January 1, 1967, considerable work had been done to pave the way for it. Its first two years were characterized by careful and extensive planning, the completion of some feasibility studies and the formation of a number of standing committees and a central staff.

Since becoming operational January 1, 1969, this heart disease, cancer, and stroke program has entered a new phase which is concerned with the actual administration of funded projects and, at the same time, with the continuation of an expanding planning and development endeavor.

The emphasis of the program is on improved patient care. It seeks to accomplish its goals and objectives by utilizing the existing health resources of the region in cooperative arrangements that will not disrupt the present organization or procedures of these resources.

The degree of success it attains depends, in large measure, upon the initiative of the physicians (as well as other health care professionals) of the region in responding to the challenges the program offers for participating in its design for improved delivery of health care services on a regional basis.

A Continuous Process

Regionalization of health resources is its ultimate goal. Regionalization has been described as a continuous process rather than a plan which is totally developed and implemented at any point in time. Thus, the program in its current phase must continue to be vitally involved with planning on a broad scale although it has some rather sophisticated projects in operation.

While the concept is regional, the site is local. The program, by its Congressional design and subsequent guidelines, is based on local responsibility although it is largely financed with federal money. If initiative does not originate at the local level, the program will founder. This has been true from the start of the program. If individuals concerned about the future of health care in Indiana had not made application for funding such a program, there would not be one in Indiana. Participation is strictly voluntary. There is no mechanism in the federal legislation (Public Law 89-239) for compelling any physicians or paramedical personnel, medical schools, hospitals, voluntary or public health agencies, clinics, professional associations or any other group or individual to participate.

Indiana Regional Medical Program is based on the innate desire of people at the local level to determine their needs in health care and to enter into voluntary cooperative arrangements to meet those needs.

History and Background

The program, as it now stands, is an outgrowth of efforts begun by the President's Commission on Heart Disease, Cancer, and Stroke early in 1964. Then President Lyndon B. Johnson, in addressing the commission, said: "Unless we do better, two-thirds of all Americans now living will suffer or die from cancer, heart disease, or stroke. I expect you to do something about it."

The commission submitted its report, entitled "A National Program To Conquer Heart Disease, Cancer, and Stroke," in December, 1964. Early in 1965, legislation was introduced in Congress. It was based on the commission's report, but information presented at hearings on the legislation by spokesmen for practicing physicians and community hospitals, as well as other groups and individuals with an interest in the health care system, helped change some of its basic concepts.

The commission stated: "A creative partnership must be forged among the nation's medical scientists, practicing physicians, and all of the nation's other health resources so that new knowledge can be translated more rapidly into better patient care. This partnership should make it possible for every community's practicing physicians to share in the diagnostic, therapeutic and consultative resources of major medical institutions. They should similarly be provided the opportunity to participate in the academic environ-

*Director of Community Relations, Indiana Regional Medical Program.

ment of research, teaching and patient care which stimulates and supports medical practice of the highest quality."

The commission had envisioned a detailed federal blueprint for action. But the act, as passed by Congress and signed into law by the President in October, 1965, rejected this idea. Specifically, the network of "regional centers of excellence" recommended by the commission was replaced by the concept of "regional cooperative arrangements" among existing health resources.

The act established a system of grants to enable representatives of health resources to exercise initiative in identifying and meeting local needs within the area of the categorical diseases through a broadly-defined process. It is intended to provide the means for conveying to the medical institutions and professions of the nation the latest advances in medical science for diagnosis, treatment and rehabilitation of patients afflicted with heart disease, cancer, stroke and related diseases —and to prevent these diseases.

Medical schools, research institutions, hospitals and other medical institutions were encouraged to achieve these ends by education and demonstrations of patient care. Through these means, the programs authorized by the act are also intended to improve generally the health manpower and facilities of the nation.

To implement the provisions of the new law, the Division of Regional Medical Programs was created in the U.S. Department of Health, Education and Welfare in February, 1966. This division now is known as the Regional Medical Programs Service and is a part of the department's Health Services and Mental Health Administration.

Since that time, 55 regional medical programs have been established across the country and in the trust territories. All 50 states are included in these regions which cover areas ranging from the size of a city and its surrounding counties to the expanse of several states.

Background of Indiana Program

Interest at the national level in the regional medical programs legislation was reflected in Indiana in 1965. Several discussions about how Indiana might be able to participate in such a program resulted in formation in September, 1965, of a study committee to investigate the matter. The outcome was that a number of statewide health care agencies, institutions and individuals encouraged this committee to recommend requesting funds with which to plan and create an Indiana Regional Medical Program.

A Regional Advisory Group was formed and held its first meeting on July 21, 1966, to organize and to begin processing an application for a planning grant. A number of special, ad hoc "task force" committees were appointed to begin the gathering of information and to formulate planning activities for the consideration of the advisory group.

The Regional Advisory Group was, and is, made up of health care providers and consumers representing every geographical area of the state and every facet of the health care community. It is the policy-making body of the regional medical program. It has broad responsibilities, including the approval of all project grant applications before they are forwarded to the federal government.

At the second meeting of the group on September 14, 1966, the task force committees made their reports, and the planning grant application was finalized and approved. The program was started on the assumption that the entire state of Indiana would comprise the Indiana region. This decision was later substantiated through findings of the Regional Characteristics and Medical Resources Committee of the program.

The awarding of a three-year planning grant of $821,505, effective January 1, 1967, was subsequently announced by the Division of Regional Medical Programs (now known as the Regional Medical Programs Service) of the U. S. Department of Health, Education and Welfare. The planning funds were awarded to permit planning for essentially two purposes:

1. Continuing and postgraduate education for physicians and other health care personnel.
2. The development of a cooperative system for delivering the best possible care to patients with heart disease, cancer, stroke and related diseases throughout the region.

Continuing Education Significant

Many of the concepts and objectives of the Indiana Regional Medical Program coincided with the central elements of the continuing and postgraduate medical education efforts of the Indiana University School of Medicine. The school of medicine was developing this program, which came to be known as the Indiana Plan for Statewide Medical Education (now called The Indiana Program), for some time before the regional medical program legislation was enacted. This program was based on a concept that the school should form educational partnerships with physicians and community hospitals over the entire state. This plan recognized the importance of continuing education for health personnel, and gave them the opportunity to acquire a working knowledge of the latest medical and scientific advances.

A continuing inter-relationship between the Indiana Regional Medical Program and this postgraduate education effort of the school of medicine is maintained so that emphasis in the postgraduate program is expanded as much as possible into the categorical disease areas with which IRMP is concerned. The In-

diana program reaches into every section of the state (region) with its emphasis on continuing education, thereby fulfilling partially the RMP goal of regionalization.

Similar inter-relationships are being established with other schools and school departments in the health field throughout the region. Indiana Regional Medical Program cooperates with the Indiana University School of Nursing and departments or schools of nursing at other universities in the region in developing postgraduate education opportunities for practicing nurses and aides. The Division of Allied Health Sciences of the I.U. School of Medicine and the far-flung regional campuses of I.U. are interested in continuing education for allied health disciplines. They also are a part of the cooperative relationships being developed through Indiana Regional Medical Program.

This emphasis on continuing education is directly in accord with the emphasis of the legislation as interpreted by Dr. Stanley W. Olson, director of the Regional Medical Programs Service. He has called continuing education "the most significant single component of regional medical program activity."

To accomplish the other basic RMP purpose, a cooperative system for delivering the best possible patient care, a number of inter-related projects have been initiated, developed and funded. These projects have resulted from the activities of the original task forces and, later, the work of standing committees. These committees have memberships broader than the Regional Advisory Group and contain a great deal of medical and technical expertise in the categorical and related diseases.

Practicing physicians throughout the region have played an important role in the planning, development and review work done by these committees. Physicians held 103 of the total of 184 positions on the standing committees earlier this year. Seventy different physicians were involved. They worked with hospital administrators, medical center officials, voluntary and public health agency representatives, persons from the allied health sciences field and representatives of other organizations, institutions and agencies concerned with the health care field.

Several of these projects now are operational and are reaching into many communities and areas of the entire region. They are:

1. *Regional Stroke Program*—This project is designed to improve existing care and to initiate care that is not available for stroke patients throughout the region. Teams made up of physical and occupational therapists and speech pathologists are being created for areas which cover all parts of the region. They outline and supervise education and treatment programs in hospitals which request the service. Continuing education is being provided for nurses and therapists in an acute cerebral vascular disease ward at the I.U. Medical Center.

2. *Multi-Phasic Health Screening for Metropolitan Indianapolis*—Goal of this project is to screen up to 10,000 persons a year in the disadvantaged, inner-city areas, using a battery of 25 tests at two screening centers, to detect health abnormalities and to introduce persons found to have abnormalities into the health care system.

3. *The Development of a Network of Coronary Care Units Throughout the State of Indiana*—This project is providing consultation and continuing education services to hospitals and health professionals in ideal coronary care as delivered in a hospital coronary care unit. A five-bed CCU at an Indianapolis hospital is used as a model demonstration and training unit for physicians and nurses.

4. *A Regional Cancer Program Feasibility Study in Tumor Registries*—This one-year project is studying the feasibility of establishing a program of regional tumor registries as a method of upgrading the care of cancer patients throughout Indiana by insuring continuity of therapy and rehabilitation.

5. *Community Health Centers for Metropolitan Indianapolis*—Through this project, new methods for providing modern, personal and efficient health care for the deprived urban areas of the city are being studied. Three centers have been created and a broad program of patient care in the areas of heart disease, cancer and stroke, coupled with an expanded emphasis on health education and preventive medicine, has been undertaken. These operational projects and the operational and planning activities of the central staff call for a 1969 budget of $1,644,329.

Additional projects have been approved by the Regional Advisory Group and the National Advisory Council of the Regional Medical Programs Service, but have not yet been allocated funds by RMPS. These include the following:

1. *A Statewide System of Continuing Nursing Education Linked with Indiana Regional Medical Program*—This project is designed to provide an organizational framework for the development of a regionwide system of continuing education for registered nurses. This system will be coordinated with already established and projected demonstration, education and research projects of IRMP.

2. *An Educational Program Preparing Registered Nurses to Function in Coronary Care Units*—This project provides continuing education for registered nurses on nursing in coronary care units. The project will offer a series of three, four-week intensive courses of theory and clinical experience, using the clinical facilities of two Indianapolis hospi-

tals. A two-day, follow-up seminar is offered about four months after the intensive course. Consultation visits to Indiana hospitals regarding in-service education programs or other problems related to CCU nursing care will be made by the project director.

3. *Expansion of Medical Library Extension Service to Support IRMP*—The aim of this project is to provide rapid access to medical information in the field of heart disease, cancer, stroke and related diseases to the entire medical community of the region. The extension services of the Indiana University School of Medicine Library would be expanded through local public libraries throughout the region. These services include teletype service to libraries, free photocopying, alerting service and consultation with hospital libraries.

4. *Establishment of a Pediatric Heart Disease Program*—This project proposes to improve care of infants and children with cardiorespiratory disease in the region and to establish a teaching and demonstration center to train health personnel in optimal pediatric cardiac care. Doctors and nurses throughout the region would be eligible to attend short, continuing education courses at the demonstration unit. Personnel from the project would hold conferences in at least six areas of the region at least twice yearly.

5. *Fetal/Cardiovascular Monitoring for Optimal Perinatal Care*—This project would establish a network of fetal intensive care units within the region. The foundation of the network would be a central model unit which would demonstrate the role of fetal/cardiovascular monitoring techniques as a component of optimal health care. Monitoring techniques would be incorporated into the framework of selected labor and delivery units in hospitals in the region and optimal perinatal care would be effected in the present health care service.

Two other projects may receive grants for 1970 from the program's unexpended 1969 funds. They are "Expansion of the Health Manpower Recruitment Program Conducted by Indiana Health Careers, Inc." and "A Cooperative Arrangement for the Education and Practice of Prospective Medicine." The latter project is conducted by Methodist Hospital of Indianapolis. These projects were approved, but not funded, as a part of the region's first operational grant request. Both have been included in requests for permission to use the unexpended funds, but approval has not been given to date.

Still other projects are in the development and review process of the program. They include a proposal to form a computerized Health Data Bank with joint funding from Comprehensive Health Planning and RMP, a Clinical Cancer Seminar proposal, a continuing education project for medical technologists and an extensive Community Coronary Care Program in four counties in northwest Indiana.

New Directions Indicated

Involved health care professionals, institutions, organizations and the program's central staff are striving to make Indiana Regional Medical Program truly regional in all aspects.

At a recent meeting of the Regional Advisory Group, its chairman, Joseph B. Davis, M.D., of Marion, Indiana, pointed out that IRMP is a regional program, with its region being the state of Indiana. "I believe we are becoming a regional program, and emphasis is being given to the fact that the program is broader than just those activities based here in Marion County," Dr. Davis said.

Lowell Steen, M.D., of Whiting, Indiana, president-elect of the Indiana State Medical Association and a member of RAG, also spoke at this meeting which was held in the ISMA building in Indianapolis. Dr. Steen said it was particularly appropriate that the group should meet at ISMA headquarters since IRMP is, basically, a medical activity that is applicable to the entire region. ISMA has made its building available to RAG for future meetings, also.

Activities of the personnel involved in operational projects and feasibility studies of the program and the functioning of its central staff and standing committees now are extending into all areas of the region. One example of this kind of sub-regionalization is the IRMP Cancer Committee. This committee has set up 13 areas, or sub-regions, coinciding with ISMA districts of the state. An area adviser has been named for each and these advisers now are in the process of forming area committees made up of representatives from several disciplines and health interests in their areas. Each of these subcommittees will study its local needs, resources and priorities and attempt to design projects that will aid in providing opportunities for improved care in the field of cancer.

Another example is the local action group organized in northwest Indiana through the combined efforts of IRMP, northwest Indiana Heart Association, practicing physicians, nurses, professionals in other disciplines, hospital personnel and representatives of the public. This committee, headed by a physician, is structuring a comprehensive program of community coronary care. As now foreseen, it will encompass as many as eight distinct, yet interrelated, projects in which many disciplines and a number of funding sources may be involved.

The Regional Stroke Program, funded by IRMP, is still another example of regionalization of resources and personnel. Through this program, therapists now are serving a number of hospitals throughout Indiana which formerly did not have

the benefit of their expertise in the management and rehabilitation of stroke patients. One therapist (a circuit rider) may provide this kind of service to as many as five hospitals.

The expertise of specialists in the coronary care field is being shared with an ever-increasing number of hospitals operating or planning to install coronary care units and with the medical and nursing personnel who operate or will operate them. Some thirty hospitals in Indiana now have CCU's or combination ICU-CCU's and the CCU project of IRMP has been involved with providing consultation to most of them. Only 14 such units were operating when the committee which planned the project began its study last year.

It is anticipated that the activities of projects such as those in stroke and coronary care will catalyze new cooperative arrangements throughout the region that will result in further regionalization of resources. The cooperative arrangement at the local level is the lifeblood of any regional medical program because it has the capability, better than any other process, of determining local needs and opportunities and, when it has done so, of working with others to meet these needs and take advantage of the opportunities.

Those now active in regional medical programs in Indiana recognize distinctly the need for others to become active in it in all areas of the region. Health professionals in communities and areas of the region are invited by the IRMP Regional Advisory Group and its central staff to make their ideas for cooperative efforts known so that assistance, if needed, can be provided.

RESOLUTION

WHEREAS, there is an Indiana Regional Medical Program in operation for the past two years with the Indiana University Foundation as the fiscal agent, and,

WHEREAS, a number of operational projects now have been funded in the Indiana region through grants made under this program, and,

WHEREAS, the process of regional cooperation begun by Indiana Regional Medical Program offers many opportunities throughout the state for active involvement by practicing physicians as well as all components of the regional health care community, and,

WHEREAS, three presidents of the American Medical Association and several state medical associations have endorsed the concepts and the purposes of Regional Medical Programs and their goal of bringing about reductions in death and disability from heart disease, cancer, stroke and related diseases,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association endorse the concept of regional medical programs in Indiana because it is medically oriented and is one of the few federally financed programs that gives initiative to people at the local level,

AND BE IT FURTHER RESOLVED, that the Indiana State Medical Association encourage member physicians to support the objectives and plans of the Indiana Regional Medical Program and to help determine ways in which they and agencies and institutions with which they are affiliated might become involved in this broadening regional cooperative arrangement. ◄

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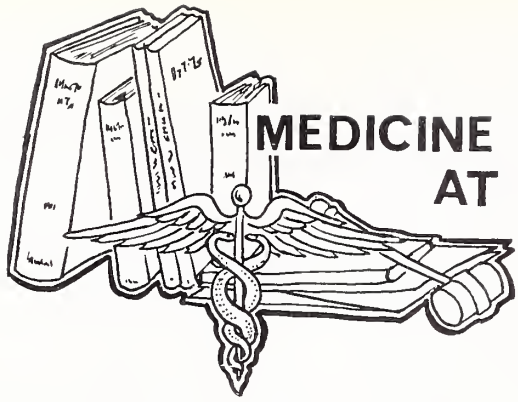
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Jury Deadlocked in Amputation Case—In a suit against a physician by a nine-year-old patient whose "good" leg had to be amputated when gangrene developed while it was in Bryant's traction, an Illinois trial court deadlocked, 7-5 for the physician.

The patient's left femur was fractured in an automobile accident. Both legs were placed in Bryant's traction. Gangrene developed in the patient's right leg, and that leg had to be amputated. It was also necessary to remove muscle and tissue from the patient's left leg.

The hospital where the patient was treated settled the patient's claim against it for $104,000. The physician settled for $71,000.—*Herron v. Garfield Park Community Hospital,* Cir. Ct., Cook Co., Docket No. 67L-15859 (Ill., May 22, 1969).

No Physician-Patient Relationship in Emergency Room Case—A patient's suit against a physician for injuries sustained and for the death of her child, which were allegedly caused by his failure to come to a hospital emergency room to treat her when she was in labor, was properly dismissed, a Texas appellate court ruled. The physician was under no duty to treat the patient because no physician-patient relationship existed. Nor could the physician be held liable for the negligence, if any, on the part of the emergency room nurse. The evidence failed to establish that she was his agent.

The patient, who was seven months pregnant, came to the hospital emergency room at 2:00 a.m., claiming that she was bleeding and was in labor. She lived in Garland and was visiting in the area served by the hospital. The patient testified that the nurse who examined her and telephoned the physician, who was on call for the emergency room, told her that she would have to go to her own physician. The child was born an hour after she left the hospital, while she was being taken by car to a hospital in Sulphur Springs. The child lived about 12 hours.

The physician testified as follows: he had never seen or spoken to the patient and had never agreed to treat her; he had received a telephone call from the nurse about what was probably the patient's case; he told the nurse to tell the patient to call her physician to find out what he wanted her to do; he heard nothing further about the matter until he was served with the complaint in this suit.

There was evidence that the hospital did not require staff members on call for emergency room service to see all patients who present themselves at the emergency room.

The patient could have a cause of action against the physician only if he had a duty to treat her. The existence of that duty must flow from the relationship of physician-patient. The existence of the physician-patient relationship is dependent upon contract, either express or implied, and a physician is not liable for arbitrarily refusing to treat even a person urgently in need of assistance if the relationship does not exist.

There was absolutely no evidence here of any contract, express or implied, which could give rise to the physician-patient relationship. The physician was thus under no duty to examine or treat the patient. His advice that the patient call the physician who had been treating her to find out what he wanted her to do was not only reasonable but was within the bounds of professional ethics. That advice could not be construed as an acceptance of the patient's case so as to bring the physician-patient relationship into existence.

The patient's testimony indicated that the nurse did not accurately relay the physician's advice to the patient—that the nurse told her she should go to her physician, rather than merely call him. However, the physician was not liable for any negligence on the nurse's part in relaying his advice to the patient. There was absolutely no evidence that the nurse was his agent. Moreover, since the patient was going to Sulphur Springs, rather than Garland, when the birth occurred, she apparently did not interpret the relayed words to be in the nature of treatment by a physician who had accepted the responsibility of treating her case.—*Childs v. Weis,* 440 S.W.2d 104 (Tex., March 28, 1969; rehearing denied, April 25, 1969).

Movies of Patient's Present Condition—A judgment of $75,000 against an anesthesiologist was set aside by a Louisiana appellate court, and the case was remanded to the trial court for the purpose of receiving additional evidence on the patient's injury and disability.

The patient claimed that he had sustained a permanent disability, particularly of the left leg, as a result of the anesthesiologist's allegedly negligent administration of a spinal anesthetic. At the trial, the patient and some of his witnesses testified

that he constantly walked with a limp or with great difficulty.

While the anesthesiologist's appeal from the judgment against him was pending, the anesthesiologist obtained motion pictures of the patient which he claimed proved that the patient was under no disability from the standpoint of walking. The anesthesiologist's request to be permitted to show the movies at the argument of the appeal was denied by the appellate court. However, the court said, it was convinced of the anesthesiologist's sincere belief that the pictures would materially affect the question of the amount of damages and perhaps also reflect on the credibility of the witnesses involved. Therefore, the ends of justice would be better served by remanding the case to the trial court so that pertinent evidence relative to the patient's injury and disability may be introduced by both parties.—*Herbert v. Travelers Indemnity Company*, 221 So. 2d 619 (La., April 7, 1969; rehearing denied, May 5, 1969).

"Hippie" Held Not Mentally Incompetent—The evidence was not sufficient to support a trial court's finding that a "hippie" was mentally incompetent, a Florida appellate court ruled. The finding and the order based thereon under which he was committed to a mental hospital were nullified.

The "hippie," who was 26 years old, had attended several colleges intermittently and worked sporadically for the past eight years. His beliefs in love and nonviolence and his personal conduct brought him into conflict with his father, mother and stepfather. He resented the attitude of his mother and stepfather toward an illegitimate child whom he had fathered. He at one time threatened or considered suicide and on one or more occasions threatened his mother with bodily harm. In an altercation which developed between the "hippie" and his stepfather when he brought a Negro girl to the home of his mother and stepfather, the stepfather was injured. After this incident, the "hippie's" mother filed the incompetency proceeding.

The two physicians who examined the "hippie" did not testify at the hearing but their report of the examination was admitted in evidence. The report stated that the "hippie" was incompetent, the apparent cause being schizophrenia. They said that he suffered from "hallucinations which were delusional, inappropriate affect, and dictatorial confusion."

A psychologist who had examined the "hippie" testified that he was sane and rational in all respects. He said that the "hippie's" condition would be "more accurately characterized as a character disorder rather than schizophrenia, manic, or any of the psychotic sources." He stated that although some of the beliefs espoused by the "hippie" represented philosophies with which many would disagree, and that his conduct and manner of speech would be considered by some to be socially inappropriate, those tendencies were not indicative of psychological incompetencies.

The "hippie" admitted that his inability to conform his beliefs and standards of values to those of his father, mother, and stepfather gave rise to considerable friction between them and himself. He denied having suicidal tendencies or propensity to do violence to anyone. He said that his frequent adolescent behavior was due to the fact that he had been encouraged to depend to too great an extent on his parents for financial support and had never fully assumed the responsibility for taking care of himself.

The trial court found the "hippie" to be mentally incompetent by reason of schizophrenia and committed him.

The fact that the "hippie" may have been suffering from schizophrenia was not sufficient justification for committing him. There was no evidence that he had mismanaged or dissipated any property of which he was possessed, or had ever become the victim of designing persons. The fact that he chose to lead the kind of life, entertain beliefs, and engage in conduct that was offensive, repulsive, and objectionable to others did not necessarily indicate mental incompetence or justify confining him in a mental hospital primarily to alleviate the financial drain on his parents and the embarrassment that he was causing them. —*In re Sealy*, 218 So. 2d 765 (Fla., Feb. 13, 1969).

Existence of "XYY" Syndrome Not Proof of Insanity—In a prosecution for kidnapping and rape, a California trial court ruled that proof that the accused had one more male chromosome in each cell than a normal male—the "XYY" syndrome—was not sufficient to establish that he was legally insane.

The accused contended that, because of the extra chromosome, his body chemistry was such that he was subject to ungovernable desires and was thus legally insane.

The prosecution argued that the accused's genetic makeup had little or nothing to do with his violent behavior, and that his behavior was more likely due to the fact that he came from a home with a brutal father and an indulgent mother.

The trial court said that research in the field of genetics was 30 years short of the point where it could be used in the courts, and that until more research was done, a ruling that the XYY syndrome was proof of insanity was not warranted.—*News Release*, Los Angeles, Calif., March 8, 1969.

Possible Paranoid Held Competent—A man accused of first degree murder and other serious felonies was competent to stand trial, even though he might be suffering from paranoia, a federal trial court

ruled. However, the court refused to permit him to waive counsel and conduct his own defense.

An accused is competent to stand trial if he has sufficient present ability to consult with his attorney with a reasonable degree of rational understanding and if he has both a rational and factual understanding of the proceedings against him. The testimony of the psychiatrists and the prison warden established that the accused met this test. The fact that he might be suffering from paranoia did not mean that he was unable to cooperate with counsel.

The court said that an accused who might be suffering from paranoid delusions should not be entrusted with the sole conduct of his own defense, particularly when the offenses are as serious as those charged here, and named counsel to represent him.—*Government of the Virgin Islands v. Niles*, 295 F. Supp. 266 (Virgin Islands, Feb. 10, 1969).

Psychiatrist's Report Used in Sentencing—In determining the sentence to be imposed on an accused who had pleaded guilty to a charge of forcible rape, a trial court's use of a report made by a psychiatrist to the court in chambers, without the accused's knowledge, was not improper, the Arizona Supreme Court ruled. The use of the report was not an abuse of discretion and did not deprive the accused of a fair and impartial hearing.

After pleading guilty, the accused requested a hearing for the presentation of evidence for the mitigation of sentence. At the court's suggestion, the accused consulted the phychiatrist for an examination. The psychiatrist was told that he should make his report to the court.

The psychiatrist refused to make a report to the accused before the mitigation hearing. He did, however, report personally to the court. He told the court that, in his opinion, the accused was a sociopath and that he did not believe that he could be rehabilitated even after 10 years of intensive treatment. The psychiatrist did not testify at the mitigation hearing.

However, a second psychiatrist who had examined the accused on two occasions testified. He stated the opinion that the accused stood a good chance of being rehabilitated if he were placed on strict probation.

The accused was sentenced to not less than 15, nor more than 25, years.

The trial court's consideration of the first psychiatrist's report did not violate the physician-patient privilege. The mitigation hearing was not a trial.

Nor did use of the report deprive the accused of a fair and impartial hearing. The accused knew that the report was to go directly to the court. He made no attempt to subpoena the psychiatrist at the time of the hearing, but elected to base his case on the second psychiatrist's testimony. Nor did he avail himself of the opportunity to examine the first psychiatrist—an opportunity that was granted to him by a post-hearing order of the trial court.—*State of Arizona v. Nelson*, 448 P.2d 402 (Ariz., Dec. 13, 1968).

AMA-MRP Deposits Not Exempt in Bankruptcy—The deposits made by a physician in the American Medical Association-Members Retirement Plan were not exempt from the claims of his creditors in a bankruptcy proceeding, a federal trial court ruled. There was nothing in the Keogh Bill or in any other federal statute which made the deposits exempt. Nor was the physician an "employee" within the meaning of the Wisconsin statute which makes an employee's interest in a retirement plan exempt from execution.

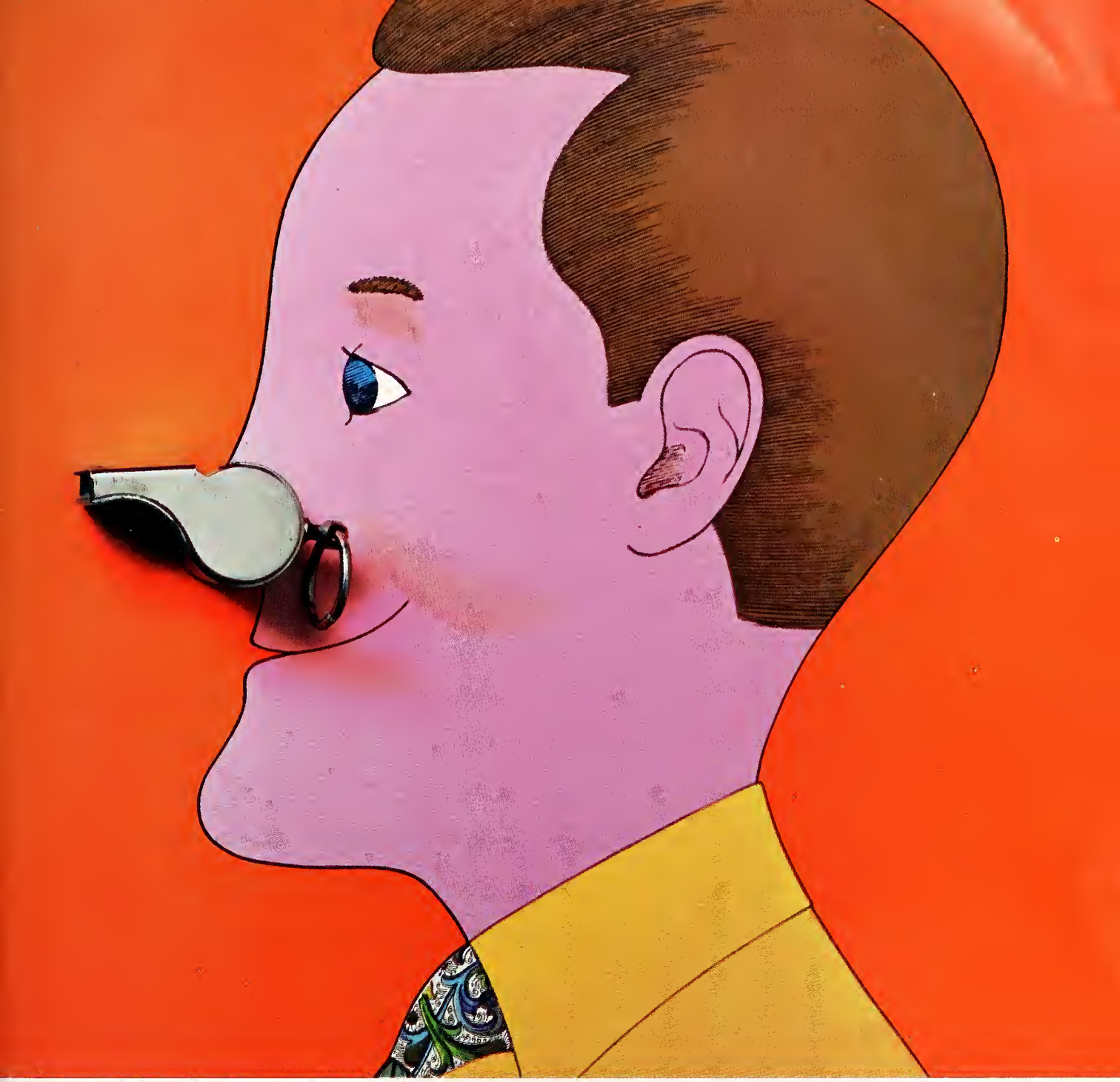
The physician was a resident of Wisconsin. He was a self-employed person. The Bankruptcy Act allows to a bankrupt the exemptions from execution that are provided for by the laws of the state of which he is a resident.

The physician contended that the deposits were exempt from execution under the Wisconsin statute which makes an employee's interest in a retirement plan created by his employer exempt from execution.

The statute exempts only employee retirement benefits and was not intended to provide protection or exemption for employers. It was immaterial that the AMA plan provided that an owner-employee was an employee within the meaning of the plan. The terms of the agreement between the AMA and the physician could not broaden or change the terms of the Wisconsin statute.—Reference: Francis X. Krembs, Esq., 735 North Water Street, Milwaukee, Wisconsin 53202.

Medical Treatises as Evidence—The Rhode Island legislature has enacted a statute making statements of opinion or fact contained in a treatise, book, periodical, or pamphlet admissible in a medical malpractice case. The statute requires, as a condition for the admission of such statements, a finding by the trial court that the statements are relevant and that the maker thereof is an expert on the subject. The statute further requires the party intending to use such published materials to give 30 days advance notice of such intention to the other party.

The statute has been editorially condemned in the journal of the state medical society. It is the society's position that such statements should not be admitted because they would not be subject to cross-examination. The society claims that such statements are very often opinions, not subject to proof as fact, and that they become obsolescent as medical science rapidly changes.—*Rhode Island Session Laws*, H.B. No. 1833 (R. I., May 16, 1969); News Release, Providence, Rhode Island, July 4, 1969. ◄



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ABSTRACTS, BOOK REVIEWS

PAUL WOOD'S DISEASES OF THE HEART AND CIRCULATION

Third edition, revised by his colleagues and friends, J. B. Lippincott & Co., Philadelphia, 1968; 1164 pp. with numerous tables and figures; $30.00.

When the first edition came out in 1950, it was an instant success. It was a matchless, one man magnum opus. If anything, the second edition made the monograph even more prestigious. Dr. Wood died just as he was beginning the work on the third edition. After much soul searching, some two dozen of his colleagues and friends gave the present volume their all.

The high standards set by Wood have been maintained to a most commendable extent. The expositions are lucid and crisp: that is all to the good. Rather surprisingly, just plain, ordinary proofreading errors abound. Thus, on p. 574, a whole line has disappeared from the text of the second paragraph. Also, on this same page, the word is SENSITIZE—not sensitise.

The paper and type are superb; the illustrations remain very clear and understandable. There are other texts in a class with Wood's: e.g., Friedberg's "Diseases of the Heart." Nevertheless, the present updated edition of Wood's classic monograph can be recommended without reservations.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

PAIN AND THE NEUROSURGEON, A FORTY-YEAR EXPERIENCE

James C. White, M.D., F.A.C.S., William H. Sweet, M.D., D. Sc., F.A.C.S., with the assistance from others in certain sections (psychiatry and stereotatic surgery of the thalamus), Charles C Thomas, Springfield, Ill., June, 1969; 965 pages, including bibliography, plus author index and subject index; $37.00.

This tome makes very "heavy" reading, as it weighs six pounds, but as one proceeds, the intellectual energy radiating from it counterbalances gravity and one reads on and on with much delight at having found a gem of clinical medical research in a setting of good English. The book is in two parts: the first "contains clinical descriptions of the otherwise intractable painful conditions that the neurological surgeon is asked to relieve"; the second contains "an evaluation of present-day operations for interruption or mitigation of pain and suffering, together with comments on the most effective methods of carrying them out in order to ensure maximum relief and freedom from complications." This is the authors' second monograph on this subject (the first in 1955, same publisher), and where our state of knowledge regarding anatomy, surgical technics, etc., remains the same as in 1955, the reader is referred to the first book, in order to save space here.

As one proceeds, the implication of the subtitle, "A Forty-Year Experience," pervades every page with the sense of certainty that these men have "been there" and know whereof they speak. Yet there is great candor in revealing how they have learned from past mistakes and misconceptions. At the end of many discussions there is a summing up (in italics), in addition to the "conclusion" at chapter's end, which for practicality, honesty, and clarity I have seldom seen equalled. In addition to their own experience, the authors respect the work of others and are frank in its appraisal. The bibliography contains over 1,400 entries.

To the non-expert in this field it is a revelation to find how difficult it is, many times, to determine the cause of pain and to choose the optimum treatment for these intractable cases. As Wilder Penfield says in his "foreword," "problems of radical relief of intractable pain are not as simple as some of us thought in the outset."

This being the case, the average practitioner can be thrice bewildered by such perplexities but in this book he can find quick answers, given in straightforward language, backed up by years of experience.

The authors' general advice is best passed on in their own words: "To recapitulate, we advise recourse to surgery for relief of pain when the sufferer from cancer with even a moderate life expectancy begins to require medication stronger than codeine. For victims of certain painful varieties of chronic visceral disease we believe that surgical intervention should be considered, provided the patient is a reasonable operative risk, just as soon as it has been established that conservative treatment cannot salvage him from serious incapacity and continued suffering. The decision to operate is made most easily in cases of tic douloureux and glossopharyngeal neuralgia, in which the results of surgery are so predictable. In contrast, the decision is most difficult in many of the post-traumatic neuralgias, particularly in the painful amputation stump and phantom limb. Here eventual failure is most

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common and we are generally reluctant to intervene until the emotional background has been investigated and it is evident that the subject can no longer live with his discomfort without recourse to habit-forming drugs. All these sufferers should be told frankly just what they have to face in the way of risk to life, serious complications, or chance of failure in exchange for neurosurgical relief. The decision for operation must be made by the patient himself, and operation can be undertaken only with his complete knowledge and cooperation."

This book should be in every medical library.

A. W. CAVINS, M.D.
Terre Haute

ELECTROPHORESIS—TECHNICAL APPLICATIONS —BIBLIOGRAPHY OF ABSTRACTS

B. J. Haywood, Humphrey Science Publishers, Inc., Ann Arbor, Mich., 1969; 440 pp.; $18.75.

Specialization is all around us: I'm really becoming used to having it shadow me all day long. Still, this is my very first contact with a beautifully bound, quite expensive, monograph that deals in abstracts only!

There are 500 background references. There are over 1,100 abstracts of relatively recent vintage: from 1965 right into 1969! The abstracts are just that: in a scanty paragraph, the reader is given the gist, the essence of what the author had to say. To say the least, the busy pathologist is saved a lot of literature scanning.

No practitioners of medicine will want this volume on their working shelf. Just as obviously, the directors of laboratories and hospitals will find this monograph (if that is what it is) a must in their daily endeavors.

Apparently, Professor Haywood did the reviewing all by himself! I can only muse at the endless hours he must have dedicated to this labor of love!

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

Abstracts From Various Literature, Prepared by AMA

FIXED COMBINATIONS OF ANTIMICROBIAL AGENTS

Drug Efficacy Study, National Academy of Sciences (201 Constitution Ave., N.W., Washington, D.C.)

New Eng. J. Med. 280:1149-1153, (May 22), 1969.

A review of the claims put forward for the use of penicillin-sulfonamides, penicillin-streptomycin, and certain other fixed combinations of antimicrobial agents has convinced five panels organized under the auspices of the National Academy of Sciences-National Research Council that such combinations are ineffective as fixed-dose combinations. Although the individual active ingredients may be useful in specific entities, no greater effectiveness can be expected for the combination than for any one ingredient. Use of a proper dose of one ingredient may require excessive inadequate doses of the other. It is the judgment of the panels that the use of these fixed combinations should be discontinued and that the physician should use the individual components according to his best clinical judgment.

SURVIVAL TIMES AFTER CARDIAC ALLOGRAFTS

B. J. Messmer et al. (Texas Medical Center, Houston)

Lancet 1:954-956, (May 10), 1969.

Fifteen patients underwent cardiac transplantation for end-stage heart disease. Their survival time is compared with that of 42 potential recipients who did not receive allografts. Mean survival of the potential recipients was 74 days. The average for the transplant patients was 111 days (including 22 days waiting time before operation). This difference does not justify wide clinical application of cardiac transplantation, but is an indication for its use in suitable cases to prolong life and relieve symptoms.

FIBERGLASS DERMATITIS

B. K. Fisher and J. D. Warkentin (409 Medical Center, Calgary, Canada)

Arch. Derm. 99:717-719, (June), 1969.

Fiberglass dermatitis was observed in a wife and her husband after their clothing was washed in the same washing machine with a fiberglass curtain. Under the microscope, scrapings from skin lesions treated with 20% KOH showed the presence of glass fibers. This dermatitis could easily be prevented if fiberglass curtains and similar apparel would have a label warning against washing of clothing in the same machine with the fiberglass-containing materials.

LIGHT SYNCHRONIZATION OF CIRCADIAN RHYTHM IN PLASMA CORTISOL (17-OHCS) CONCENTRATION IN MAN

D. N. Orth and D. P. Island (Vanderbilt University School of Medicine, Nashville, Tenn.)

J. Clin. Endocr. 29:479-486, (April), 1969.

To determine whether the pituitary-adrenal cycle of normal man is synchronized by the dark-light cycle, normal subjects underwent a partial dissociation of this cycle from the sleep-wake schedule. Each slept from 10 PM to 6 AM, and the schedule of meals and activity was identical for all. Only the dark-light schedule was altered. When the hours of darkness were scheduled in the middle of the waking day, normal subjects exhibited the usual 17-OHCS peak at the time of wakening and a second peak at the time of illumination. When darkness began at 10 PM but was prolonged until 10AM, the peak occurred only upon illumination. When normal subjects were kept in total darkness except for one hour (6 til 7 PM), the wakening peak was delayed and diminished and a second major peak occurred during the brief period of illumination. The dark-light cycle may be an important synchronizer of the pituitary adrenal cycle in man.

GROSS FRAGMENTATION OF CARDIAC MYOFIBRILS AFTER THERAPEUTIC STARVATION FOR OBESITY

E. S. Garnett et al. (Southampton General Hospital, Southampton, England)

Lancet 1:914-916, (May 3), 1969.

Death from ventricular fibrillation consequent upon therapeutic starvation to ideal weight is described in an obese but otherwise healthy 20-year-old girl. At the time of death the plasma electrolytes, calcium, magnesium, pH, and blood gas tensions were normal. The extracellular fluid volume was also normal although the lean body mass was reduced. The myocardial fibers were reduced to approximately half their normal diameter, and electron microscopy revealed gross loss and fragmentation of the myofibrils. Prolonged total starvation is unsafe.

RELIABILITY OF A SELF-ADMINISTERED QUESTIONNAIRE

M. F. Collen et al. (3779 Piedmont Ave., Oakland, Calif.)

Arch. Intern. Med. 123:664-681, (June), 1969.

A self-administered patient questionnaire comprising 204 commonly used inventory-by-systems questions was tested as to its reliability. By testing and retesting each medical question both on forms and on cards, it was shown that inconsistency in responses was not related to the mode of questioning, but to the content of the questions. For the total of 204 questions, 95% of the patients changed their answer to less than six percent of the questions. Patients were more likely to change their second answer when their first response was a "yes," than when a "no." An overall score was developed which ranked each question as to its relative reliability.

OBTAINING INFORMED CONSENT

L. C. Epstein and L. Lasagna (Johns Hopkins Hospital, Baltimore)

Arch. Intern. Med. 123:682-688, (June), 1969.

Sixty-six subjects, most of whom were female hospital employees, were asked if they were willing to take two tablets of "acetylhydroxybenzoate" or a placebo when they next had a headache, after receiving varyingly detailed descriptions of the actions and hazards of the drug. Comprehension and consent to volunteer were inversely related to length of form. In the longer form groups, two subjects volunteered to take the drug despite the presence of contraindications, and five missed the point that fatal reactions might occur. When told that the drug described was in fact aspirin, 20 of 21 who had refused to take acetylhydroxybenzoate said that they would continue to take aspirin.

MANAGEMENT OF INVASIVE CERVICAL CANCER FOLLOWING INADVERTENT SIMPLE HYSTERECTOMY

T. H. Green and W. J. Morse, Jr. (8 Hawthorne Pl., Charles River Park, Boston)

Obstet. Gynec. 33:763-769, (June), 1969.

Eighty-four women in whom simple hysterectomy had been performed in the presence of invasive cervical cancer, unsuspected in most instances, were seen between 1940 and 1960. Early reoperation with radical surgical removal of the residual tumor-bearing area appears to offer the greatest chance of salvage in this unfortunate situation. In this series, 21 patients underwent radical reoperation and 14 (67%) survived five or more years. Radiation therapy has proved less successful, probably because of the technical obstacles to effective local application of radium which absence of the uterus poses. Thirty patients were given a full course of radiotherapy; nine (30%) survived five or more years. In the remaining 33 patients, the lesions were already hopelessly incurable by any means.

IDIOPATHIC RECTOSIGMOID PERFORATION

D. C. Lyon and H. J. Sheiner (Massachusetts General Hospital, Boston)

Surg. Gynec. Obstet. 128:991-1000, (May), 1969.

Six patients with idiopathic rectosigmoid perforation have been observed, and 84 patient records from the literature have been reviewed. Idiopathic rectosigmoid perforation is an acute abdominal emergency in which death is almost inevitable in the absence of surgical intervention. Approximately one-third of the patients have an evisceration of the small intestine through the anus, and of those without this complication, the misdiagnosis rate approaches 100%.

SUCCESSFUL TREATMENT OF THREE CASES OF VERY SEVERE BARBITURATE POISONING

A. C. Kennedy et al. (Glasgow Royal Infirmary, Glasgow, Scotland)

Lancet 1:995-998, (May 17), 1969

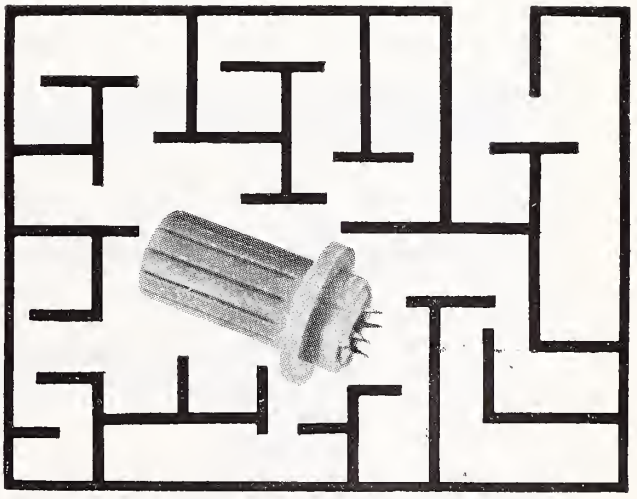
Three self-poisoned patients with extremely high serum barbiturate levels (58 mg of phenobarbitone/100 ml, 15 mg of butobarbitone/100 ml, and 14.8 mg of cyclobarbitone/100 ml) were successfully treated by prolonged hemodialysis, forced diuresis (combined in one case with peritoneal dialysis), and standard supportive measures. The blood levels are the highest ever recorded for these barbiturates. These cases illustrate the principles of management in severe barbiturate intoxication.

ABDOMINAL TRAUMA FROM SEAT BELTS

F. A. Traylor et al. (University of Colorado School of Medicine, Denver)

Amer. Surg. 35:313-316, (May), 1969.

Eight cases of abdominal injury due to the use of the lap-type automobile safety belt are reported. A contusion in the shape of the belt was on the abdominal skin of most patients. This is an ominous sign. If the lap-type belt alone is used, its correct application across the boney pelvis ring is important. As in other forms of blunt abdominal trauma, careful and prolonged evaluation is necessary, with early laparotomy if indicated. The association of lumbar spine injuries is stressed. The use of the shoulder strap in conjunction with the lap belt substantially reduces the frequency of abdominal injuries. ◄



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INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—September, 1969

Disease	Sept. 1969	Aug. 1969	July 1969	Sept. 1968	Sept. 1967
Animal Bites	913	1221	1408	900	1134
Chickenpox	31	41	105	49	26
Conjunctivitis	74	122	150	97	43
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	5	21	25	19	32
Gonorrhea	656	685	707	555	583
Impetigo	176	189	212	247	139
Infectious Hepatitis	46	21	32	29	33
Infectious Mononucleosis	36	20	33	46	41
Influenza	588	272	237	701	226
Measles					
Rubeola	1	1	14	8	5
Rubella	26	38	75	36	9
Meningitis, Meningococcal	1	2	1	6	4
Meningitis, Other	3	4	3	2	6
Mumps	56	93	99	76	82
Pertussis (whooping cough)	8	3	9	21	50
Pneumonia	139	137	173	101	99
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	333	328	416	331	301
Syphilis					
Primary & Secondary	39	27	33	29	15
All Other Syphilis	85	81	117	121	101
Tinea Capitis	3	6	8	13	11
Tuberculosis (Active)	62	82	81	83	85

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PLACEBO — 20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

*"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

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Thiamine HCL .....10 mg.
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Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
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Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

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WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
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Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
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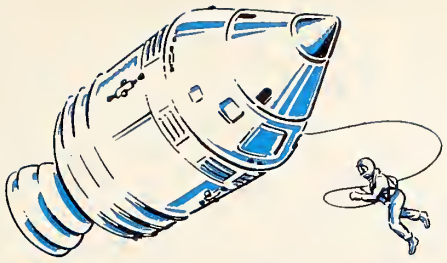
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Glutamic Acid ..... 50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE:** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRA-INDICATIONS:** See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

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Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

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Contraindications: Hypersensitivity to tetracyclines. *Warning:* In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs. *Precautions:* Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

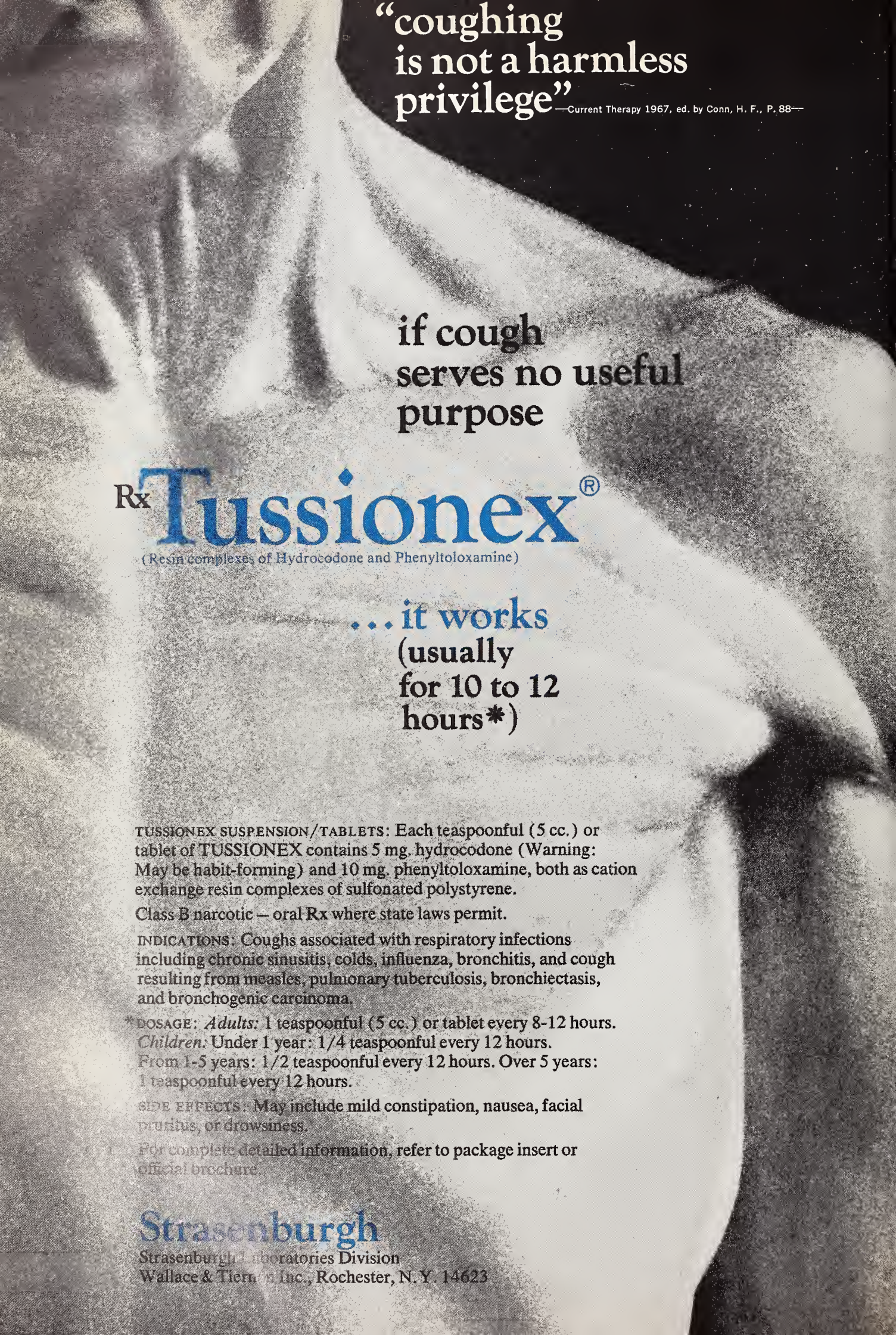
Side Effects: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

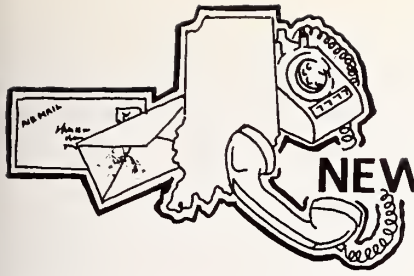
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NEWS NOTES

American Society of Clinical Pathologists Cites Dr. Montgomery

Dr. Lall Montgomery has been awarded the Distinguished Service Award of the American Society of Clinical Pathologists and the College of American Pathologists. The recognition is in the form of a plaque which cites Dr. Montgomery for "leadership and foresight and untiring efforts in behalf of all pathologists."



Dr. Montgomery has been the chief pathologist for Ball Memorial Hospital in Muncie since 1934. He is a graduate of the University of Manitoba School of Medicine and was a fellow in pathology at the Mayo Clinic for three years.

He is a founding fellow of the College of American Pathologists and for 24 years was chairman of the Board of Registry of Medical Technologists of the American Society of Clinical Pathologists. He was president of the Society in 1966-67 and has been a delegate to the American Medical Association for the AMA Section on Pathology and Physiology since 1957.

Dr. Montgomery has served numerous terms on the Editorial Board and at present is Associate Editor of *The Journal.*

Dr. Byllesby is Speaker

Dr. Joyce Byllesby, newly-elected second vice-president of the Crawfordsville branch of University Women, spoke to the group about the opportunities available to women in medicine at a recent meeting of the group. Dr. Byllesby is pathologist at Culver Hospital.

Dr. Norris Guest Speaker

Dr. Max Norris, Indianapolis, president of the Boy Scout Central Indiana Council, was guest speaker recently at the adult recognition banquet for the Northwest District at Lebanon.

Dr. Shevick Honored

Dr. Alexander Shevick, Valparaiso, became an honorary member of the Crown Point High School chapter of the Future Farmers of America recently at ceremonies at the annual Parent-Son banquet at Crown Point. Dr. Shevick received his plaque and the chapter's appreciation for his encouragement of its activities, specifically in the area of horticulture.

Dr. Hill Speaks

Dr. Theodore A. Hill, superintendent of Beatty Memorial Hospital, Westville, spoke on "Community Mental Health—Who and What Does This Include" at a banquet included as part of the Community Mental Health Week and Mental Retardation Workshop for LaGrange County.

Workshop on Worries

Drs. William Abell and Rodney Caudill, Anderson, were leaders of classes recently at a Women's Worry Clinic, sponsored by the Madison County Mental Health Association. The workshop was designed to provide help with problems common to all ages of women.

Dr. Chamblee Knighted

Dr. Roland W. Chamblee, South Bend, has been appointed for Knighthood in the Order of St. Gregory the Great, for his outstanding service and contributions to the church. Dr. Chamblee has held office in numerous civic organizations and has been prominently identified with many civil rights movements in South Bend. He has also been the recipient of numerous awards for his work in the field of social justice.

Dr. Thompson Honored

Dr. John M. Thompson, South Bend physician and eye surgeon, was honored recently as "doctor boss" of the year by the St. Joseph County Medical Assistants.

John Shaw Billings History of Medicine Society December Meeting

Dr. Roy Behnke, Indianapolis, will be the principal speaker at the December 10 meeting of the John Shaw Billings History of Medicine Society.

"Historic Aspects of Lung Cancer" will be his topic. Each program is preceded by a social hour and dinner on the mezzanine of the Student Union Building, Indiana University Medical Center at Indianapolis, beginning at 6:30 p.m.

Continued



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NEWS NOTES

Continued

Dr. Harvey Leads Discussion

Dr. Emerson C. Harvey, medical director of Delco Radio Division, Kokomo, led the discussion recently of two films shown during a police workshop sponsored by the Howard County Mental Health Association. Purpose of the program was to help law enforcement officers identify and handle mentally ill persons.

Dr. Bowers Speaks

Dr. Garvey B. Bowers, Kokomo, presented a program of slides and comments on his world travels recently at the Kokomo Public Library. His program was entitled "Travels the World Around."

Dr. Pirkle Honored

Dr. Hubert Pirkle, Rockville, was this year's recipient of the Auerback Award, presented by the Indiana Tuberculosis Association. This award is presented each year to a TB worker who has made a significant contribution to the fight against TB over a period of years.

Dr. Kohlstaedt Named

Dr. Kenneth G. Kohlstaedt, Indianapolis, has been named a regent-elect of the American College of Physicians.

Dr. Culbertson Named New Pathology Chief



Dr. Clyde G. Culbertson, pathologist at Eli Lilly & Company has been elected president of the American Society of Clinical Pathologists. Dr. Culbertson was named to the new position at the group's annual meeting recently in Chicago.

Other officers elected included Dr. Robert J. Frost, Michigan City, as secretary-treasurer.

New ACS Officers

New officers of the American College of Surgeons, Indiana Chapter, were elected recently at the chapter's annual meeting.

The officers for 1969 and 1970 are: **Drs. Donald Schlegel, Indianapolis,** president; **William F. Oren, South Bend,** president-elect and **J. E. Arata, Fort Wayne,** re-elected secretary-treasurer.

Dr. Davis Passes Board

Dr. Claude E. Davis, Angola, has passed the American Board of Surgery Specialty Examinations given in Nashville, Tenn. Dr. Davis became the second physician in Steuben County to achieve this distinction; **Dr. Richard W. Artz, Angola,** also passed the examination.

Named President

Dr. Richard S. Bloomer, Rockville, has been elected president of the Parke County Tuberculosis Association.

Dr. Offutt Speaks

"Challenge and Response in Our Service to the Aging" was the topic of **Dr. Andrew Offutt,** Indiana Health Commissioner, when he spoke before a recent seminar sponsored by the Indiana Association of Homes for the Aged and Aging.

Dr. Bennett Named Head

Dr. James E. Bennett, director of plastic surgery at the I.U. School of Medicine, has been named national chairman of the Plastic Surgery Research Council.

ISMA-Inspired Route Markers To be Given Trial in Region V

ISMA-inspired highway directional signs for emergency medical service facilities will be given a trial in Region V of the Emergency Medical Service Plan. The region includes Kosciusko, LaGrange, Steuben, Noble, DeKalb, Whitley, Allen, Huntington, Wells and Adams Counties.

The directional highway markers are the result of work of the ISMA Commission on Emergency Medical Services under the chairmanship of Dr. John S. Farquhar, Jr., of Fort Wayne. The sign will conform in size and shape to the state highway road sign. It will carry the AMA universal medical emergency alert symbol and will indicate the number of miles and the direction to the nearest emergency facility.

Dr. Grosz on Panel

Dr. Hanus J. Grosz, professor of psychiatry at the I.U. School of Medicine, participated in a special panel discussion on self-help for former mental patients at the recent annual meeting of the American Psychiatric Association.

Elected to Board

Dr. Horace E. Jones, Anderson, has been elected to the board of directors of the Indiana Tuberculosis Association. He will serve a three-year-term.

Dr. Welch is Speaker

Dr. Norbert E. Welch, Vincennes, spoke recently before a meeting of the Deacons of Westminster Church in Washington, Ind. Dr. Welch gave a talk and showed slides of his recent three-month-tour of Thailand working with the medical missionaries.

Present Lectures

Michigan City physicians have been presenting lectures to the Northwest Regional Institute Schools of Radiologic Technology at St. Anthony's Hospital there. Physicians who have currently donated their time are: **Drs. Francis Kubick, John F. Kerrigan, Charles Liddell, Gene Hay, Edward Mladick, Raymond O'Brien and William Stark.**

Physicians scheduled for future lectures include: **Drs. Rodney Mannion, B. V. Ticsay, John Luce, Robert Gilmore, Robert Frost and Walter S. Milne.**

Dr. Ringer Speaks

Dr. William A. Ringer, Williamsport, discussed the heart cardiogram before a recent meeting of the Attica-Williamsport Rotary Club.

Cancer Conference

Dr. Jacob W. Scheeres, Lafayette, participated in a one-day cancer conference for nursing personnel of Northwestern Indiana Health Care Facilities recently at St. Elizabeth Hospital.

Therapists Meet

Speaker at a recent meeting of the Indiana Chapter of the American Association for Inhalation Therapy was **Dr. W. F. Ricchetti, West Lafayette,** staff physician at St. Elizabeth Hospital. His topic was "Anatomy of the Lungs."

"Prevent Children's Accidents" Booklet Now Available for Patients

"Prevent Children's Accidents" is the title of a 15-page booklet written by John H. Cramer, vice president of CNA Financial Corporation. It is written for parents and contains practical suggestions which have been developed from a study of the insurance files.

Copies may be obtained at 25 cents each by writing Children's Accidents, Booklet Department, National Research Bureau, 424 N. 3rd St., Burlington, Iowa 52601. Quantity prices are available on request.

New VA Director

James F. Haile, who served as a captain in the Air Corps from 1942 to 1945, and who has most recently been director of the VA Center at Wadsworth, Kansas, has been assigned as director of the VA Hospitals in Indianapolis.

Dr. Steigmeyer Speaks

Dr. David Steigmeyer, Fort Wayne, reported on the progress of treatment and research of cystic fibrosis at the recent annual dinner meeting of the Cystic Fibrosis Chapter in Fort Wayne.

Addresses Cancer Society

Dr. Otis R. Bowen, Bremen, was the featured speaker at the annual meeting of the Allen County Cancer Society recently in Fort Wayne. Dr. Bowen discussed the implications of the recent legislative session, particularly as it pertains to health and welfare problems of the state.

Dr. Kintner on Panel

Dr. Burton Kintner, Elkhart, recently participated in a panel which discussed the dangers of drugs before the meeting of the YWCA's Public Affairs Forum in Elkhart.

Heads Shrine Class

Dr. John D. MacDougall, Noblesville, has been elected president of the Steven L. Miller Class of the Scottish Rite at Indianapolis.

Indiana Schools Given Smith, Kline & French Grants and Awards

The Smith, Kline & French Foundation made grants and awards in the amount of $908,970 during 1968 for educational purposes and charitable and community improvement projects.

Schools receiving matching gifts in Indiana include Butler University, DePauw University, Goshen College, Purdue University, and the University of Notre Dame.

Series on Drugs

Dr. Frank C. Campbell, Anderson, was speaker recently at the first meeting in a drug abuse seminar at the Bethel United Methodist Church in Anderson.

Continued

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Continued

Physicians Honored

Drs. William R. Clark, Jr. and Fouad Halaby, Fort Wayne, were honored recently by a Gold Heart Award for service in the fight against heart disease from the Allen County Heart Association. Dr. Clark was also elected president-elect of the association at the meeting.

Drug Abuse

Information on drug abuse was furnished all seventh grade pupils in LaPorte recently through the cooperative effort of LaPorte schools and physicians. A film was shown and the following physicians warned against the dangers of glue sniffing, marijuana, LSD and heroin: **Drs. Robert M. Kelsey, E. C. Mueller, Jack C. Richter, James J. Sprecher, G. P. Backer and M. B. Backer.**

Dr. Kidder Named

Dr. O. T. Kidder, Fort Wayne, has been renamed medical director the Allen County Tuberculosis Association.

Dr. Smith Appointed

Dr. Lloyd Smith, North Manchester, has been appointed chairman of the Wabash Chamber of Commerce hospital committee.



Dr. Bernoske Speaks

Dr. D. G. Bernoske, former Michigan City physician and health officer, spoke recently at the LaPorte County Tuberculosis Association annual meeting. Dr. Bernoske, director of the Bureau of Medical Services of the Indiana State Board of Health, spoke on the changes taking place in tuberculosis treatment.

New Anti-Smoking Movie Now Available to Physicians

An anti-smoking movie based on a dramatic true story has been filmed for free-loan use by community groups. It is a 25½ minute 16 mm-sound color film suitable for all groups and especially health associations.

Filmed in Hawaii, the movie is based on the illness and death of Mark Waters, a newspaperman whose self-written obituary was reprinted by *Reader's Digest.* For free-loan and scheduling date write Modern Talking Picture Service, 118 E. Michigan St. Indianapolis 46204.

PTA Speaker

Dr. William F. Blaisdell, Seymour, participated on a panel entitled "This is Your Child's Health" at a recent meeting of the Emerson Parent Teachers Association at Seymour.

Dr. Waldo Elected

Dr. Guy H. Waldo, Bedford, has been elected an associate member of the American College of Physicians.

Dr. Dukes Honored

Dr. Betty Dukes, Dugger, has been elected third vice-president of the Indiana Mental Health Association.

Physician Speaks

Dr. David E. Wynegar, Richmond, spoke at a recent meeting of the Advisory Committee on Alcoholism at the Fort Wayne YMCA. Dr. Wynegar is medical director of the Alcoholism Treatment Program at Richmond State Hospital.

PMA Announces Continuation Of Clinical Pharmacology Awards

The Pharmaceutical Manufacturers Association Foundation has announced the continuation of its award program in the field of clinical pharmacology. Two-year awards are made to scientists who wish to pursue expanded educational opportunities.

The purpose of the program is to stimulate teaching, training and research in clinical pharmacology. Dr. Glenn W. Irwin, Jr. Dean of Indiana University School of Medicine, is a member of the Advisory Committee which recommends recipients.

Dr. Kleit Speaks

Dr. Stuart A. Kleit, Indianapolis, spoke to Indiana dietician recently at a meeting of the Indiana Dietetic Association in Indianapolis.

Dr. Martz Named

Dr. Carl D. Martz, Indianapolis, has been elected to the board of trustees of the Pension Fund of Christian Churches (Disciples of Christ). The pension fund provides retirement disability and death benefits for ministers, missionaries and other full-time church workers.

Continued on page 1360

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



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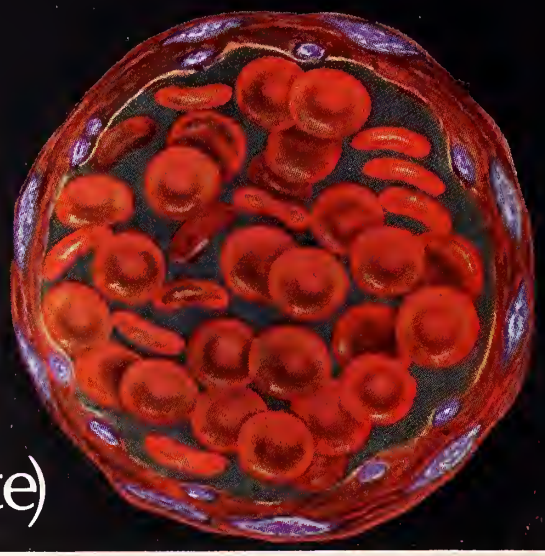
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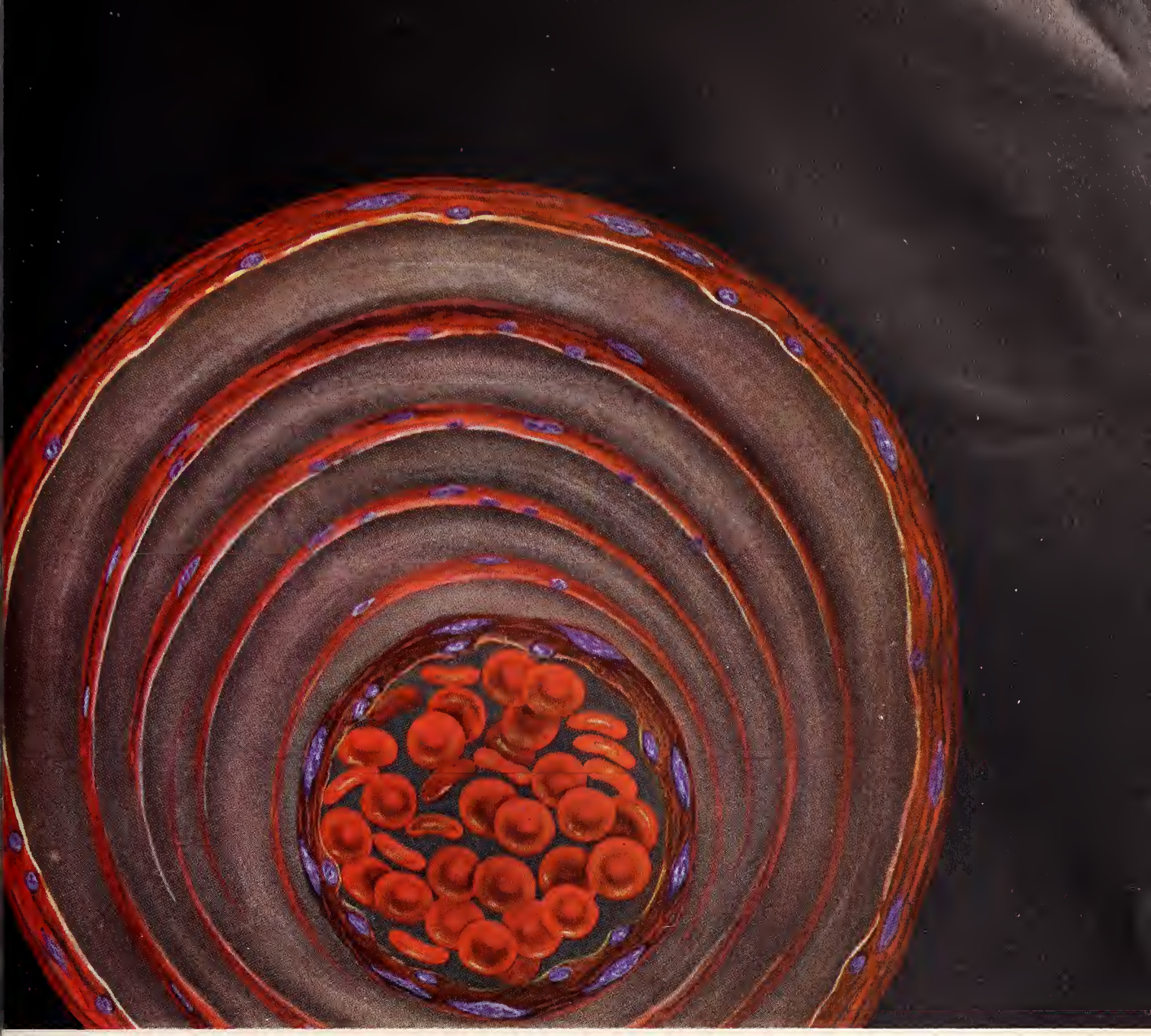
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Roniacol Timespan (nicotinyl alcohol tartrate) can make a significant contribution to effective treatment of peripheral vascular disorders. It is directed specifically toward improvement of peripheral blood flow, relief of ischemic symptoms, and the long-term management of these conditions.

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mooth peripheral vasodilation from initial osage...extended with imple, well-tolerated, b.i.d. dosage

e prolonged action of Roniacol Timespan cotinyl alcohol tartrate) together with its ıer benefits offer a therapeutically practical asure in the long-term management of ipheral vascular disease–advantages ecially important for older patients.

ore prescribing, please consult complete duct information, a summary of which lows:

lications: Conditions associated with icient circulation; e.g., peripheral vascular ease, vascular spasm, varicose ulcers, ubital ulcers, chilblains, Meniere's syn-me and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt—bottles of 50 and 500.

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Art is a conception of peripheral vasodilation.


Food 'n mouth disease

udin® phenmetrazine hydrochloride
udin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).

traindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.

ning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.

Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning.

Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.
Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000.
(B)R3-46-560-B

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For complete details, please see full prescribing information.

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For some, obesity can be a serious complication of moderate hypertension, diabetes, or pregnancy.

Preludin may be used to curb appetite in obesity associated with such conditions.

For use during pregnancy, please consult Warning paragraph. The use of Preludin in moderate hypertension should be accompanied by caution. In diabetes, the drug does not increase insulin requirements (requirements may be reduced as weight is lost).

One 75-mg. Endurets tablet taken between breakfast and midmorning will usually provide daylong and early-evening suppression of appetite.

Preludin® phenmetrazine hydrochloride Endurets® prolonged–action tablets

NEWS NOTES

Continued

Dr. Middleton Speaks

Dr. Thomas Middleton, Bloomington, addressed the Northside Exchange Club of Bloomington recently on the subject of cancer.

Doctor Compiles History

Dr. Stanley M. Casey, Huntington, has completed a Medical History of Huntington County. The manuscripts have been placed in the Huntington library and the Huntington County Historical Museum.

Rotary Speaker

Dr. Vincent Hannekan, Wabash, spoke to Rotarians there recently on drug abuse.

Dr. Scamahorn Speaks

Dr. M. O. Scamahorn, Pittsboro, spoke before the Hendricks County Historical Society recently on the theme "Pioneer Pill-Pushers."

Dr. Deogracias Takes Course

Dr. Francisco Deogracias, Edinburg, recently attended a course on surgery of the hand at the New York University Postgraduate Medical School in New York City.

Chicago Medical Society Renames Clinical Conference

The Clinical Conference held early each spring by the Chicago Medical Society has become so popular and so well attended by non-Chicagoans that it is being renamed "Midwest Clinical Conference of the Chicago Medical Society."

Dr. George F. Lull, who is now Executive Vice President of the Chicago Medical Society, announces that the next conference will be at the Sherman House on March 1 to 4, 1970.

Dr. Williams Delivers

While he was addressing students at St. Joseph's College recently on "Human Sexuality," as part of an annual lecture series and explaining what is involved in childbirth, **Dr. Paul A. Williams, Rensselaer,** was called to Jasper County Hospital where an actual childbirth was about to occur.

IRS Concedes That Organizations Will Be Treated as Corporations

The Internal Revenue Service has announced, in response to recent decisions of the Federal courts, that it is conceding that organizations of doctors, lawyers, and other professional people organized under state professional association acts will, generally, be treated as corporations for tax purposes.

Implementing instructions will be issued to field personnel—if necessary on a state-by-state basis—as soon as possible. In addition, appropriate modifications of existing regulations will be required consistent with these decisions.

Dr. Bailey is Speaker

Dr. Edwin Bailey, Linton, demonstrated cardiac resuscitation and heart massage methods at a recent meeting of the Linton Business and Professional Women's Club.

Dr. Combs Elected

Dr. Stuart R. Combs, Terre Haute, has been elected directo of the professional and unclassified division of the Terre Haut Chamber of Commerce. He will serve for three years.

The Hospital's Expanding Health Care Role Explored in New Film

The American Hospital Association has issued a new motio picture which expounds the need for hospitals to extend thei services to areas outside the hospital.

Titled "Beyond the Wall," the film is a 28-minute color presenta tion. Additional information may be obtained by writing Mi lard Krebs, 840 N. Lake Shore Drive, Chicago 60611.

Hospital Specialist Moves

John R. Rowan, VA hospital administration specialist, who ha occupied personnel assignments at Fort Harrison and in Indian apolis, and who was assistant director of the Indianapolis V hospital, has been named director of the VA Hospital at Man chester, New Hampshire.

Program Speaker

Dr. John Quakenbush, Kokomo, discussed the action o drugs on the mind and body as part of a program presented re cently at Indiana University-Kokomo entitled "The Generatio Gap."

Dr. Greenlee Speaks

Dr. Joseph A. Greenlee, Avilla, spoke on tractor and high way safety recently at a meeting of the Noble County Automotive project group at Albion courthouse.

Cancer Speakers

Three Fort Wayne physicians spoke at the recent Edwin C Schouweiler Memorial Institute on Cancer. **Dr. Charles S Giffin** spoke on "Rehabilitation of the Laryngectomee;" **Dr David Gastineau** on "Rehabilitation of the Patient Undergoing Radiation or Chemotherapy" and **Dr. Jack Patterson** on "Re habilitation of the Colostomy Patient."

Dr. DuBois Honored

Dr. Charles C. DuBois, Warsaw, was honored recently on the occasion of his 91st birthday. Dr. DuBois was visited by members of the Presbyterian Church choir and many other friends at Miller's Merry Manor where he resides.

"Intensive Respiratory Care" Film Available for Showing

The Public Health Service has a new medical movie on the subject of "Intensive Respiratory Care." It is 16 mm, with color and sound, runs for 30 minutes and is cleared for television. It is intended for viewing by physicians and paramedical personnel.

Free short-term loan can be obtained by writing National Medical Audiovisual Center, Atlanta, Georgia 30341.

Joins American College

Dr. Fred M. Kuipers, Lafayette, has been named an associate member of the American College of Physicians.

On Seminar Panel

Dr. Senen Encinas, English, participated in a panel discussion at a recent seminar of the Indiana State Board of Health

held in Indianapolis. Dr. Encinas spoke on "Functioning of the Local Health Officer in Epidemiology as it Relates to Comprehensive Health Planning."

Comprehensive Health Planning Document Available to Physicians

The goals, priorities and problem areas of comprehensive health planning are reviewed in a new document issued by the Health Insurance Council.

Entitled "Community Health Action-Planning—Problems and Potentials," the 22-page publication is designed as an introductory guide to planning for business and professional leadership involved in state and community health activities.

Included is information on the history of health planning, key provisions of planning legislation, suggested organization and relationship of health agencies within a state, criteria for effective areawide planning agencies, priority actions to be taken by agencies, and barriers that may be encountered.

Copies of the health planning document may be obtained without charge from the Health Insurance Council, 750 Third Avenue, New York 10017.

1970 AAPS Essay Contest For High School Students

The Association of American Physicians and Surgeons has announced its 24th Annual National Essay Contest for high school students.

The 1970 contest will have a choice of topics, as is customary —"The Advantages of Private Medical Care" or "The Advantages of the American Free Enterprise System."

For full details write the Association at 230 N. Michigan Ave., Chicago 60601. County medical societies and their auxiliaries are invited to sponsor the contest in their local high schools.

Dr. Casey is Speaker

Dr. Stanley M. Casey was guest speaker recently for the Huntington County Historical Society meeting. He spoke on "Some Medical Men of Huntington County."

Dr. Benken Gives Talk

Dr. Lawrence Benken, Muncie, spoke on the physical and moral aspects of marriage at a recent conference to aid persons either newly-wed or who were to be married soon held at St. Patrick's Catholic Church in Kokomo.

Dr. Encinas Speaks

Dr. Senen J. Encinas, English, was the principal speaker at the recent annual meeting of the Crawford County Tuberculosis Association.

Netherlands Sugar Industry Guilty of Misrepresentation

A recent Netherlands court decision found the Netherlands sugar industry guilty of deliberately misrepresenting scientific research on cyclamate artificial sweeteners for its own economic interests.

Advertisements of two Netherlands sugar companies stated that cyclamate causes weight gain. The Netherlands sugar industry and its advertising agencies were enjoined from publishing such ads, under penalty of payment of 100,000 guilders ($27,600) for every infringement, payable to each cyclamate produced. ◄

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A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, music therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available

Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.

Assistant Professor of Psychiatry and Medical Director

Area Code 704-254-3201

Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION CLINICAL CONVENTION
Date Nov. 30-Dec. 3
Place Denver, Colo.

NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville

INDIANA ROENTGEN SOCIETY, INC.
Date March 1, 1970
Place Holiday Inn East, Indianapolis

INDIANA ACADEMY OF GENERAL PRACTICE
Date April 14-16, 1970
Place Indianapolis

INDIANA DENTAL ASSOCIATION
Date May 13-16, 1970
Place Indianapolis Hilton Hotel, Indianapolis

INDIANA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS
Date May 6-7, 1970
Place Stouffer's Inn, Indianapolis

INDIANA SOCIETY OF ANESTHESIOLOGISTS
Date May 23, 1970
Place Marott Hotel, Indianapolis

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date May 6-8, 1970
Place Morris Inn, South Bend

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 12-15, 1970
Place South Bend

INDIANA PUBLIC HEALTH ASSN., INC. & INDIANA TUBERCULOSIS ASSN. JOINT MEETING
Date April 21-23, 1970
Place Stouffer's Indianapolis Inn

AMERICAN COLLEGE OF SURGEONS INDIANA CHAPTER
Date April 16-18, 1970
Place Indiana State University, Terre Haute

INDIANA ASSOCIATION OF PATHOLOGISTS
Date December 6, 1969
Place Indianapolis Motor Speedway Motel, Indianapolis

INDIANA MEDICAL BUREAU
816 Hume Mansur Bldg.
631-5802

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FUTURE MEETINGS, SEMINARS, COURSES

American Academy of Allergy Presenting Postgraduate Course

The American Academy of Allergy will present a postgraduate course February 14 and 15, 1970, at the Jung Hotel in New Orleans in connection with the academy's annual meeting February 14 to 18.

Details of the course and the meeting may be obtained by writing American Academy of Allergy, 756 N. Milwaukee St., Milwaukee, Wisconsin 53202.

Colorado Offers "Surgery of the Hand" Postgraduate Course

The University of Colorado School of Medicine will conduct a postgraduate course on Surgery of the Hand on February 17 to 20, 1970. Colorado faculty members and four guest lecturers will conduct the course.

Tuition for the four days in $80, which includes the cost of a buffet luncheon each day. Write The Office of Postgraduate Medical Education, 4200 E. Ninth Ave., Denver 80220.

University of Iowa to Conduct Continuing Education Conferences

The University of Iowa Health Center will conduct a continuing education conference on obstetrics and gynecology on December 4 and 5, and a similar conference on cardiac and respiratory disease on December 5.

Write Office of Medical Education, University of Iowa, 100 Westlawn, Iowa City 52240.

1969 Cleveland Clinic Ophthalmic Postgraduate Course

The annual conference of the Cleveland Clinic Ophthalmology Department will be held December 10 and 11, 1969 in Cleveland, Ohio.

The title of the meeting is "Concepts in Diagnosis and Management of Diseases of Vitreous, Retina and Choroid." Guest speakers include Victor T. Curtin, M.D., Miami, Florida; Matthew Davis, M.D., Madison, Wisconsin; William S. Hagler, M.D., Atlanta, Georgia and J. Donald M. Gass, M.D., Miami, Florida.

For further information, write to the Director of Education, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

Tenth International Cancer Congress Set for May 22-29, 1970

The Tenth International Cancer Congress will meet in Houston on May 22 to 29, 1970. For complete information write the Congress at P.O. Box 20465, Astrodome Station, Houston 77025.

Indiana Section, American Chemical Society Sets One Day Symposium

The Indiana Section of the American Chemical Society has announced plans for a one day symposium entitled, "Recent Advances in Immunochemistry," to be held at the Indiana University Medical Center on December 6.

The proceedings will be carried on the Indiana Educational Television Network and will be seen at remote centers throughout the state. Chairman for the event is Dr. William Bromer of Eli Lilly and Company. The speakers include researchers from the National Institutes of Health, Indiana University, The Jefferson Medical College of Philadelphia and Burroughs Wellcome and Company.

The speakers will discuss recent advances in the areas of immunoglobulins, human tissue transplantation, antigen-antibody interactions and immunosuppressive drugs. Program is acceptable for 6 hours by the American Academy of General Practice.

Program details and pre-registration forms may be obtained by writing to Dr. R. L. Wolen, Lilly Laboratory for Clinical Research, Marion County General Hospital, 960 Locke St., Indianapolis 46202.

Indiana Thoracic Society Announces Winter Conference

A Winter Conference for physicians will be sponsored by the Indiana Thoracic Society. This conference will be a two-day session beginning Friday evening, December 5, and concluding Saturday afternoon, December 6. All sessions will be held at the Atkinson Hotel, Indianapolis.

The Friday evening session will be devoted to the presentation of interesting cases including:

1. Improvement of Ventilation With Resection of Pulmonary Cyst—Richard N. Matzen, M.D.
2. Long Term Antibiotic Therapy in Chronic Respiratory Disease—John D. Miller, M.D.
3. Pulmonary Disease Due to Mycobacteria Kansasii—Ralph C. Wilmore, M.D.
4. Long Standing Pulmonary Histoplasmosis—Arvine G. Popplewell, M.D.

The Saturday scientific session will consist of four topics:

1. Problems in Setting Up a Respiratory Disease Care Unit in a Local Hospital—Glen A. Ramsdell, M.D.
2. Pulmonary Embolism—Walter J. Daly, M.D.
3. Surgical Diagnostic Technic in Pulmonary Problems—William A. Shuck, Jr., M.D.
4. Respiratory Distress Syndrome—Duke H. Baker, M.D.

The scientific session will conclude with an address by Dr. John B. Hickam, Professor and Chairman, Department of Medicine, Indiana University School of Medicine. He will discuss "Newer Trends in Medical Education—Thoracic and Otherwise."

Respiratory Failure Course Listed by Cleveland Clinic Foundation

A course on "Respiratory Failure—Acute and Long Term Management" will be conducted at the Cleveland Clinic Educational Foundation on December 3 and 4.

Further information and programs may be obtained by writing to the Director of Education, The Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland 44106. ◄

County, District News

Tenth District

New officers of the Tenth District Medical Society are: Drs. Robert Milos, Gary, president and J. M. Siekierski, Griffith, secretary. They were elected at the annual meeting Sept. 24 at Gary. Speaker at the meeting was Johnnie Latner, Notre Dame All American and Heisman and Maxwell Trophy winner.

Eleventh District

Colonel Robert H. Lang, USAF, MC, member of the National Aeronautics and Space Administration, spoke on "Space Medicine" at the annual meeting of the Eleventh District Medical Society Sept. 17. Dr. Julius T. Steffen, Wabash, was elected president of the society and Dr. Fred Poehler, LaFontaine, was re-elected secretary-treasurer.

Thirteenth District

Dr. James D. Finfrock, Elkhart, was elected president of the Thirteenth District Medical Society Sept. 17 at that group's annual meeting. Other officers include: Drs. George M. Haley, South Bend, president-elect; J. O. Hildebrand, South Bend, re-elected secretary-treasurer and E. J. Dovey, elected to the Blue Shield board of directors.

Allen

Dr. Roy H. Behnke, Indianapolis, spoke on "The Pink Puffer and the Blue Bloater" at the Sept. 2 meeting of the Allen County Medical Society. One hundred and ten members and guests attended.

Cass

An AMA film entitled "Team Physician" highlighted the Sept. 8 meeting of the Cass County Medical Society. Forty-five members and guests were present.

Dearborn-Ohio

"Treatment of Acute Pulmonary Insufficiency" was the topic of Dr. Anthony Salem, Cincinnati, when he spoke at the Sept. 4 meeting of the Dearborn-Ohio County Medical Society.

Daviess-Martin

Dr. Joe Dukes, Dugger, met with the members of the Daviess-Martin County Medical Society Sept. 15 to discuss and explain the various activities of ISMA.

Hancock

Dr. Patrick Logan, Indianapolis, spoke on "Common Dermatologic Problems" at the Sept. 22 meeting of the Hancock County Medical Society.

LaPorte

Dr. Raymond J. O'Brien, Michigan City, has been appointed secretary of the LaPorte County Medical Society, replacing Dr. Frank J. McGue, Michigan City.

Madison

"Renal Dialysis" was the topic of a speech given by Dr. George Applegate, Indianapolis, at the Sept. 15 meeting of the Madison County Medical Society.

Tippecanoe

Dr. Peter Petrich, Attica, spoke at the Sept. 9 meeting of the Tippecanoe County Medical Society on various activities of ISMA.

Vanderburgh

Dr. Franklin A. Bryan, coordinator of medical education for the Ft. Wayne Medical Society Foundation, Inc., spoke on "The Combined Hospital Medical Education Plan in Fort Wayne" at the Sept. 9 meeting of the Vanderburgh County Medical Society.

Wayne-Union

"L-Dopa in the Treatment of Parkinson's Disease" was the topic of Dr. J. L. Armitage, Cincinnati, when he spoke at the Sept. 9 meeting of the Wayne-Union County Medical Society.

Wells

The Sept. 29 fall clinical conference of the Wells County Medical Society featured an International Symposium on Primary Amyloidosis. Speaker at the evening portion of the program was Dr. Alan S. Cohen, of the Department of Medicine of Boston University Medical School. ◄

COMMERCIAL ANNOUNCEMENTS

BUY AND TRY: Wye Plantation Aberdeen-Angus frozen semen from Advanced Register P.R.I. sires officially gaining over four pounds per day or whose 365-day weights are above 1,200 pounds. (Performance tested sires always for sale.) WYE PLANTATION, Queenstown, Maryland 21658. Telephones: 301-827-7166 or 301-827-7160.

RESIDENCY IN PHYSICAL MEDICINE AND REHABILITATION: University of Cincinnati. Four faculty physiatrists. Basic science program. Broad training in rehabilitation, electromography, and acute physical medicine. Write Robert H. Jebsen, M.D., Professor and Chairman, Dept. of Physical Medicine & Rehabilitation, University of Cincinnati, College of Medicine, Eden & Bethesda Aves., Cincinnati, Ohio 45219

WANTED: General practitioner or internist to locate in southwestern Indiana in association with overworked general practitioner. Modern office space available, with x-ray and laboratory facilities. One mile from new hospital. Write Box 357, The Journal, Indiana State Medical Association, 3935 N. Meridian St., Indianapolis, Ind. 46208.

PHYSICIAN-SURGEON: Indiana licensed; desires to relocate in Gary-Whiting area; career physician. Qualified, competent, 25 years experience: administrative ability; prefer association, will solo or accept industrial appointment. Available after January, 1970. Reply P.O. Box 1285, Lansing, Michigan 48904. Phone 517-543-0061 from 9 to 10 a.m. or 8 to 9 p.m.

GENERAL PRACTITIONER: To associate with incorporated 3-man well established group in Kokomo, Indiana. Large, fully equipped and staffed office and laboratory. Start at once. Salary open. For further information or interview, please write or call collect: R. E. Thompson, Bus. Mgr., 401 E. Reynolds Dr., Kokomo, Ind. 46901. Phone 317-453-0805.

IMMEDIATE OPENING: Internist or general practitioner to join six man multi-specialty group in northeastern Wisconsin. Excellent professional opportunity to practice in a friendly community, only two actively practicing physicians (general practitioners) in the community outside of our clinic. Salary commensurate with training and experience first year and then full partnership. Ideal, safe small city living for the family on scenic Lake Michigan with excellent fishing, boating and hunting. All this and still only 1½ hours drive to Milwaukee or 45 minutes to Green Bay or lovely Door County. For complete details contact Robert E. Myers, M.D., Garfield at 23rd, Two Rivers, Wisconsin 54241.

PSYCHIATRIST, SURGEON, GENERAL PRACTITIONER: 1518-bed predominately psychiatric VA Hospital, located in East Central Indiana. Special programs in psychiatric and geriatric rehabilitation; alcoholic treatment unit. Active medical and surgical services. Family rental units at reasonable rates usually available on hospital grounds. Thirty days of leave annually; retirement; health, life insurance plans without physical examination; and other benefits. Can pay moving expenses. Salary depending on qualifications. License any state required. Equal opportunity employer. Contact Chief of Staff, VA Hospital, Marion, Indiana 46952 or call (317) 674-3321, Extension 233.

FOR SALE OR LEASE: Large, 4-bedroom house for doctor's offices; 38th and Central area. Contact George Horton, M.D., Indianapolis, 925-4712.

OPPORTUNITY for career in occupational medicine with large corporation. Multiple locations. Salary plus fringes. Immediate openings in three locations. Give resume. Write Box 356, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

PHYSICIAN (full or part-time)—For staff position in a 200-bed modern, progressive general hospital in beautiful residential community. Salary dependent upon qualifications, ranging from $19,767 to $25,189. Excellent fringe benefits. Must be licensed to practice in a state, territory, or commonwealth of the United States or in the District of Columbia. Non-discrimination in employment. Contact Hospital Director, Veterans Administration Hospital, Fort Wayne, Indiana.

NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

First four lines: $3.00
each additional line: 50¢

Send cash with order. Average count: seven words to the line.

DEADLINE: Fifth day of month PRECEDING month of issue.

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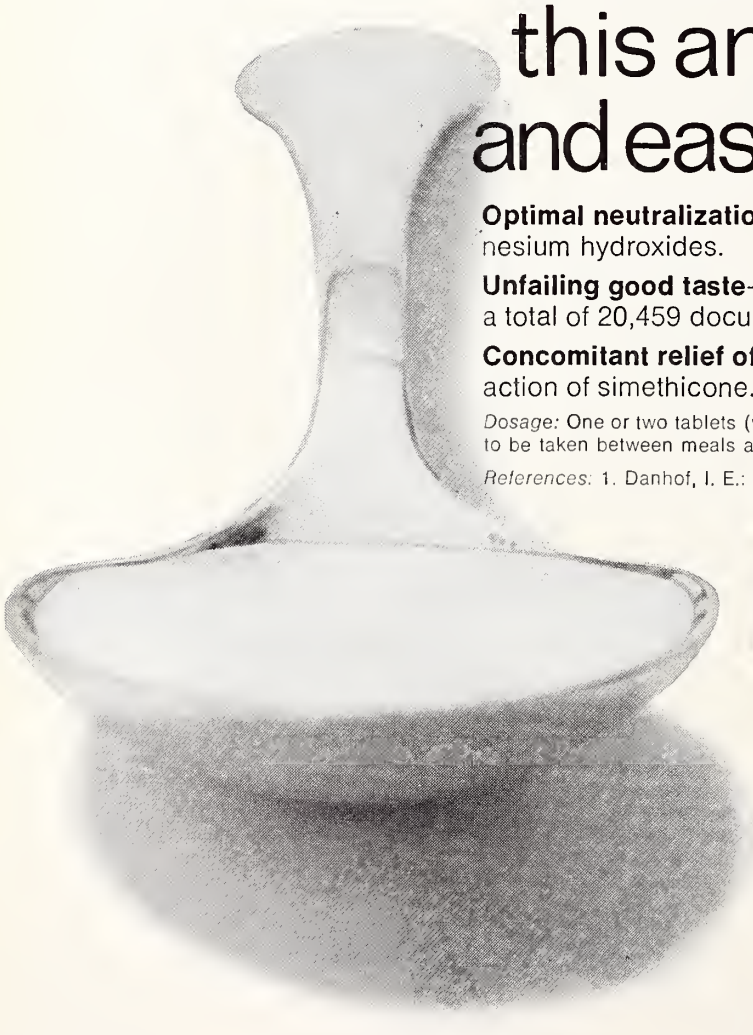
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Contents

SCIENTIFIC

The Shades of Green, George S. Allen, M.D., Georgetown 1393

Primary Malignant Tumor of the Jejunum, B. T. Maxam, M.D., Indianapolis 1398

Stenosing Non-Peptic Esophagitis, Jacob K. Berman, M.D., George A. Rowe, M.D., William M. Waymire, M.D., Indianapolis 1404

Path-Finder: Antibiotic Sensitivity Testing 1408

Electrocardiogram of the Month: Atropine in Myocardial Infarction, Charles Fisch, M.D., Indianapolis 1410

EDITORIALS

Medical Care Cost Escalator 1416

New Monthly Feature, Lloyd L. Hill, M.D., Peru 1417

What Malpractice Suits Are Doing to You, the Patient (Guest) 1417

Editorial Notes 1418

SPECIAL FEATURES

Lounge Talk, Lloyd L. Hill, M.D., Peru 1419

South American Medical Tour, Wei-Ping Loh, M.D., Gary 1427

1969 CONVENTION

1969—The Convention Story 1453

Convention Election Results: Dr. Malcolm O. Scamahorn Named President-Elect 1475

The Winners 1476

Index to House of Delegates Proceedings 1477

REGULAR FEATURES

What's New? 1385

Month in Washington 1386

Fourth Estate 1390

The Woman's Auxiliary Reports to ISMA 1420

The Blue Shield Claims Dollar: 1968 (One of a Series) 1422

Medicine At Law 1428

Abstracts, Book Reviews 1430

From The Journal 50 Years Ago 1433

Board of Health Report 1434

News Notes 1439

Annual Meeting Dates of Professional Medical and Allied Organizations 1446

Deaths 1451

County, District News 1452

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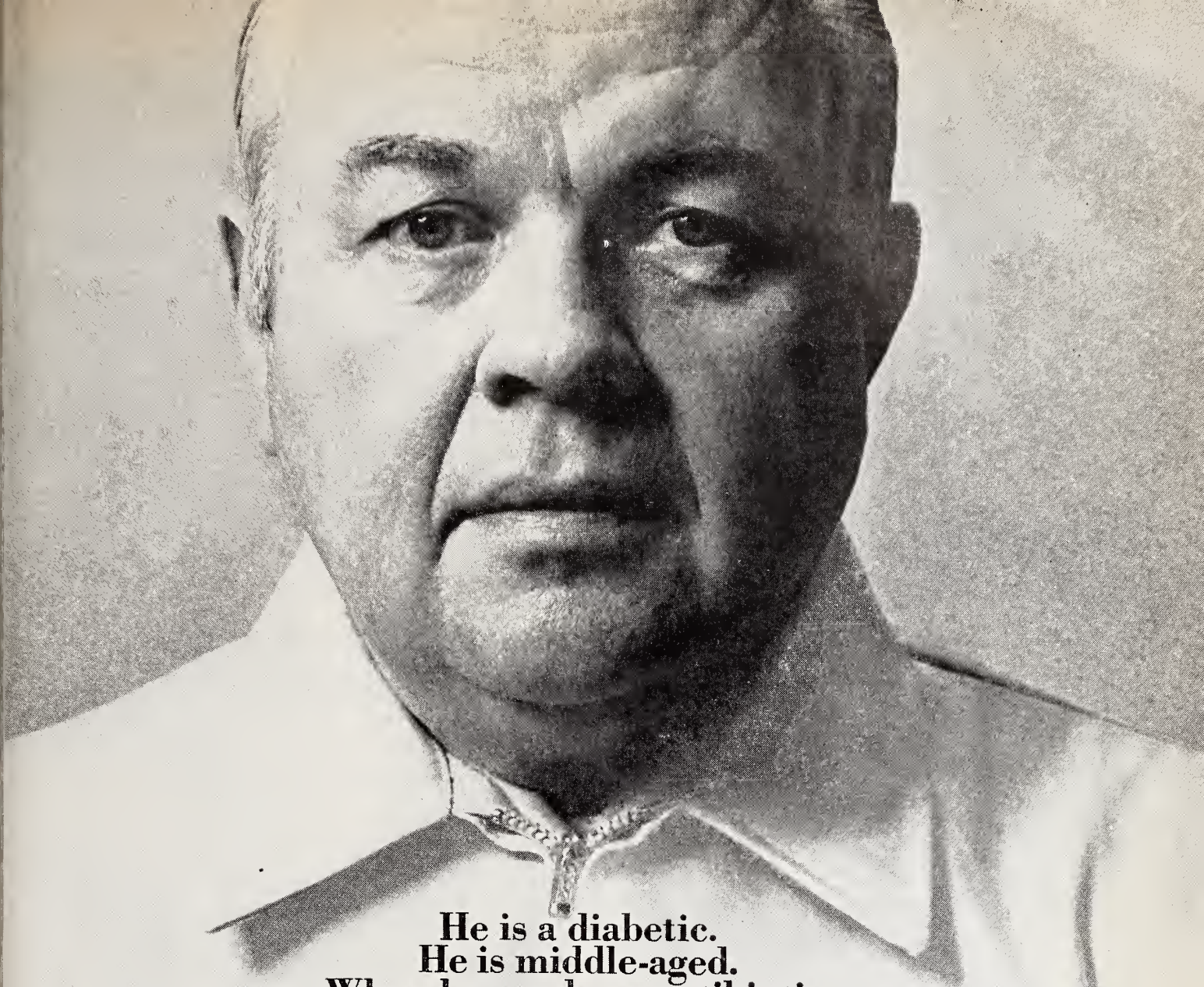
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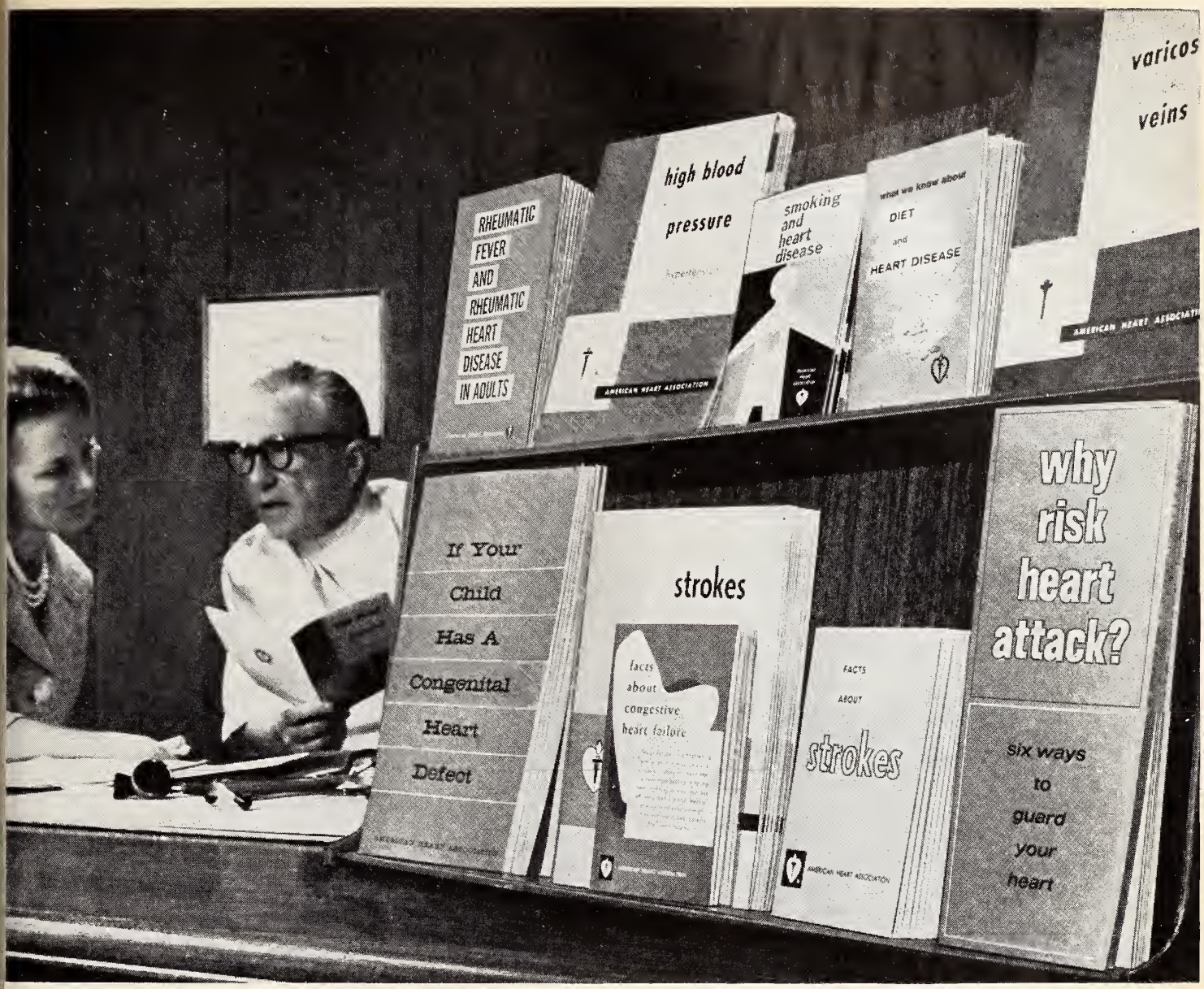
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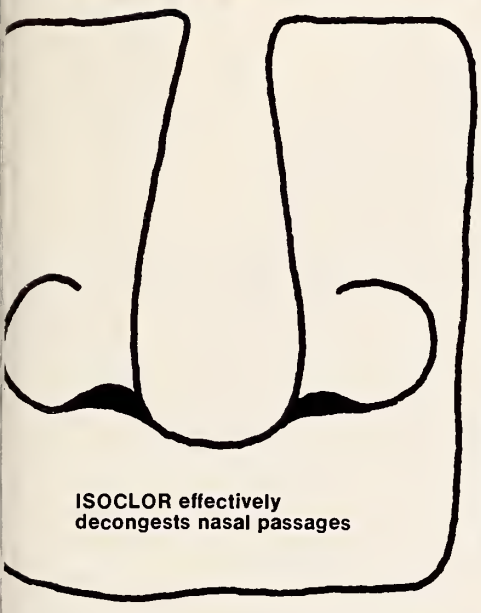
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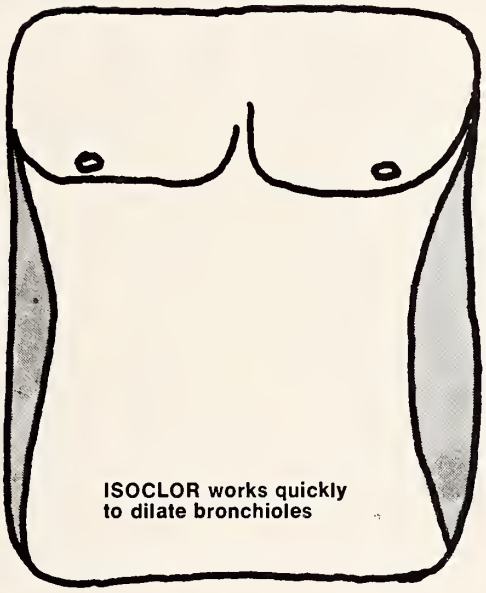
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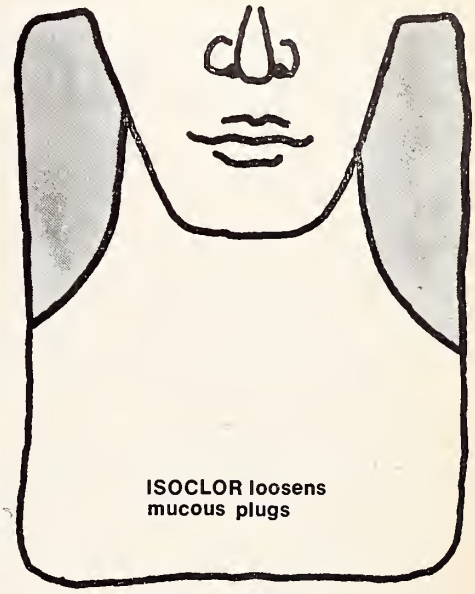
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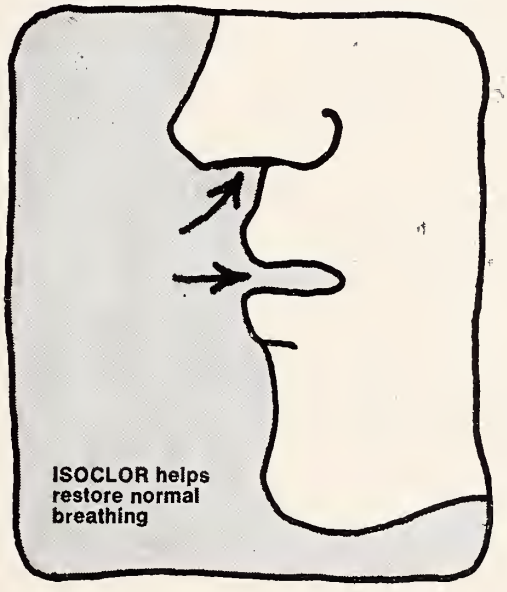
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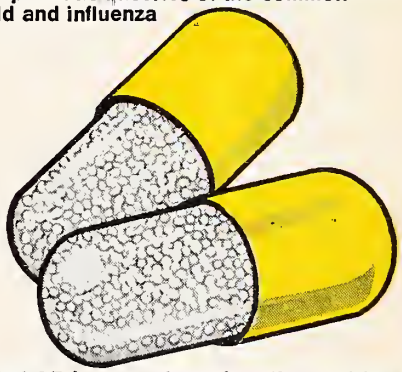


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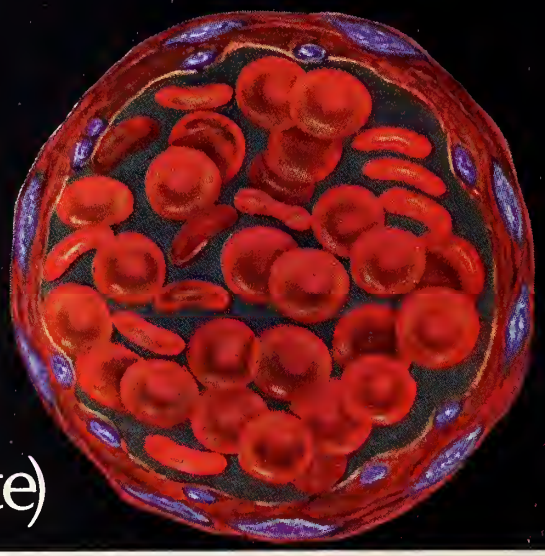
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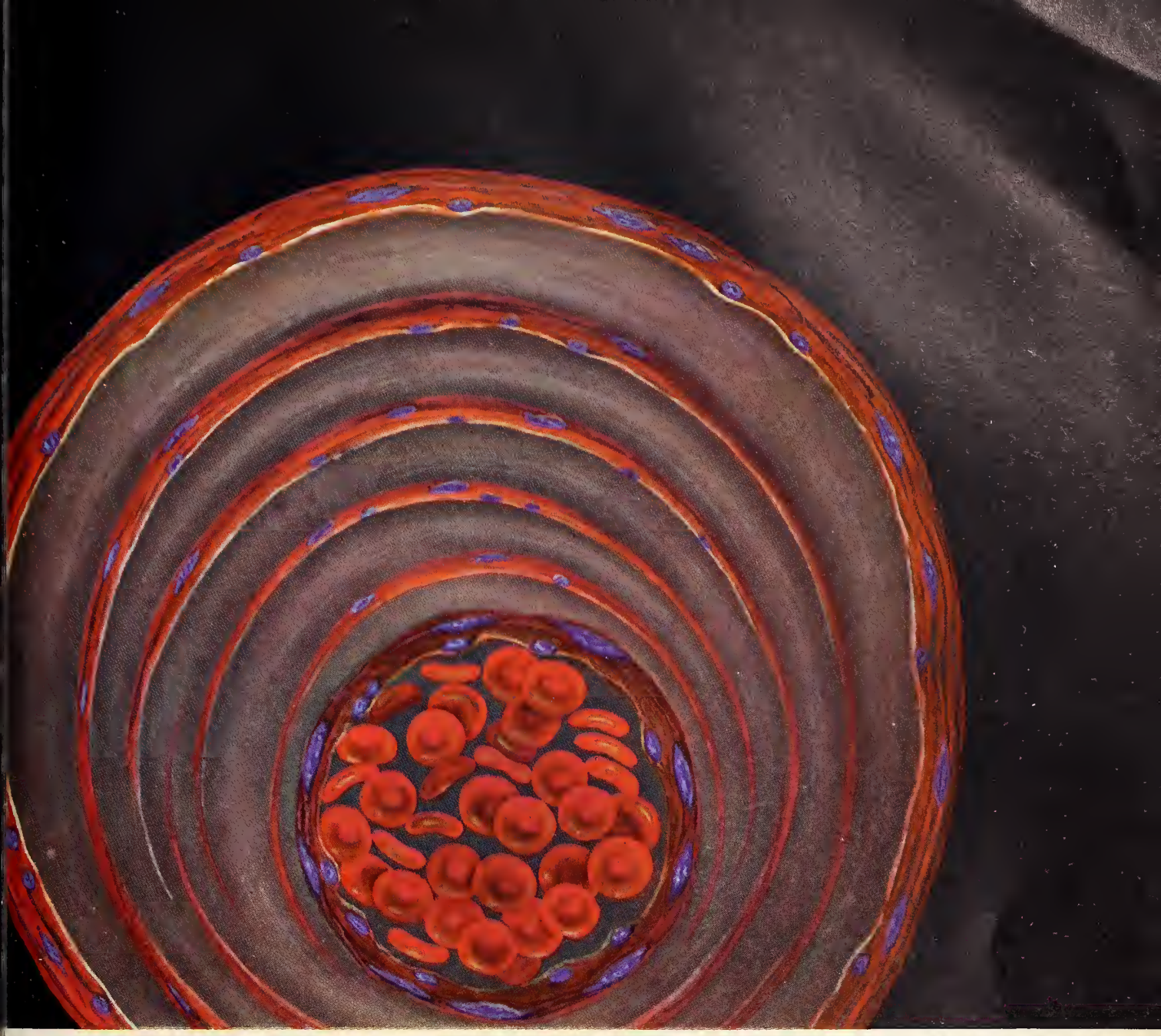
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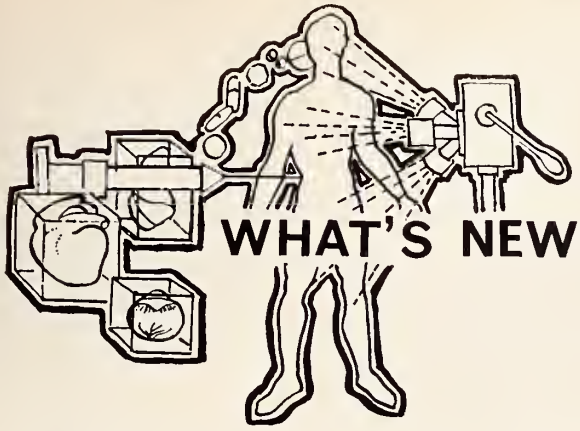
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"A Study of Carbon Dioxide Gas Absorption," a 20-page booklet published by National Cylinder Gas is available by request to 840 N. Michigan Ave., Chicago 60611. Refer to booklet No. NM 100.901. It is illustrated with color photographs and discusses factors influencing carbon dioxide absorption in anesthesia, efficiency of various absorbents, methods of packing canisters, and the use and efficiency of disposable absorbent canisters.

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Eli Lilly has reduced the wholesale prices on all forms of V-Cillin and V-Cillin K by from 10 to 22.5%. This is the fifth price cut on this product in eight years. The largest cuts will apply to the most popular tablet sizes and packages.

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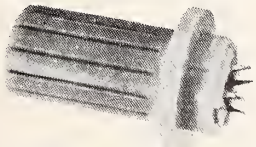
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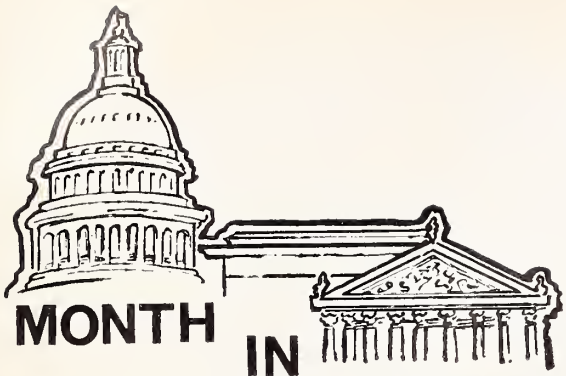
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MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

WASHINGTON—An American Medical Association spokesman outlined the AMA's voluntary national health insurance plan, "Medicredit," for consideration by the House Ways and Means Committee.

DR. RUSSELL B. ROTH, speaker of the AMA's House of Delegates and a practicing physician in Erie, Pa., said the plan, which would be financed in part by federal income tax credits, is flexible and would assure all Americans—no matter how limited their financial resources—of adequate health care protection.

"REPRESENTING this country's physicians as we do," Dr. Roth said, "the AMA is on record in its belief that it is the basic right of every citizen to have available to him good health care.

"TODAY WE WANT to put before this committee a plan which is universal in scope, voluntary in nature, and realistic in terms of total program cost."

HE ESTIMATED the program would cost the federal government $8 billion to $9 billion a year, but about $3 billion a year of that would be offset by liquidation of the medicaid program. Medicare would continue.

"FOR THOSE IN low-income categories, this protection is theirs without expense or contribution on their part," Dr. Roth said. "For those with moderate and higher levels of income, Medicredit provides a system of cash incentives to enable them to protect themselves against major health care costs. . . .

"OUR PROPOSAL IS the result of years of careful study of our existing mechanisms for delivering and financing health care, coupled with our close study of the federal government's ability to fund a universal health insurance program. . . .

"IT WOULD GIVE TO persons who have purchased comprehensive health insurance the option of receiving a tax credit on their annual federal income tax return, a credit based on their tax liability. That is, a taxpayer could take as a credit against the amount of income tax owed to the federal government, all or part of their personal cost for comprehensive health coverage. Persons or families with a lower tax liability (usually reflecting lower income or more dependents and allowable expenses) would receive a greater tax credit. And those families in the lower 30% income range, would, without cost to them, receive a certificate enabling them to purchase health coverage from qualified groups or plans."

THE AMA PLAN calls for establishment of a "Health Insurance Advisory Board" to create Medicredit guidelines. It would be chaired by the Secretary of Health, Education and Welfare and include the Commissioner of Internal Revenue and public members. It would review the effectiveness of the program and file annual reports with the President and the Congress.

ASIC MEDICAL BENEFITS of Medicredit would include:

—Up to 60 days of inpatient hospital services, including maternity services;

—All emergency room and outpatient services provided in the hospital;

—All physicians' services, whether performed in the hospital, home, office or elsewhere.

SUPPLEMENTAL benefits to basic coverage would also be eligible for tax credits.

DR. ROTH stressed the importance of utilizing private insurance carriers, thus taking maximum advantage of private sector competition to help hold cost down.

REP. DURWARD G. HALL, M.D. (R., Mo.), a former member of the AMA House of Delegates, submitted to the committee another national health insurance plan. The first part of his two-part plan calls for the federal government to furnish persons eligible for medicaid with health insurance certificates covering certain specified basic health protection. The states would have the responsibility for the balance of health care for an eligible individual after his basic coverage had been exhausted. Thus, the Hall plan would replace medicaid.

THE SECOND PART of the Hall proposal calls for the federal government helping, in cases of catastrophic illness, those persons who can afford normal health care insurance only.

OTHER NATIONAL health insurance plans are being sponsored by Walter Reuther, head of the automobile workers' union; the AFL-CIO; Sen. Jacob K. Javits (R., N.Y.), and Gov. Nelson Rockefeller of New York. Indications are that the committee will not give serious consideration to such legislation before next year at the earliest. However, it appears probable that the issue will come to a vote in Congress before the 1972 elections.

AMA STATEMENT ON HEALTH COST AMENDMENTS

THE AMA also submitted to the Ways and Means Committee a statement on the Nixon Administration's "Health Cost Effectiveness Amendments of 1969" legislation.

THE AMA commended the Department of Health, Education and Welfare for its efforts to curtail the rising costs of medicaid and medicare, but said that the association believes "there are better and more appropriate means of meeting this problem."

AS FOR THE provision prohibiting payment to physicians who have committed fraud, overcharged or otherwise abused the medicare program, the AMA said:

"IT SHOULD BE KEPT in mind that there presently exist remedies to reach the cases of abuse which may exist—certainly the cases of

Continued

Continued

extreme abuses which HEW has asserted these proposed penalties are intended to reach. While it is true that the law does not provide authority to disqualify physicians as to prospective participation, a carrier may reject or review a physician's claims on an individual basis as each claim is presented.

"THE APPARENT concern of the Congress regarding alleged abuses and increasing program costs may require some changes in the administration of federally financed health care programs. However, the proposed amendments appear to introduce more severe remedies than the problems require."

AS FOR THE provision that utilization review committees pass retroactively on the medical necessity of admission of medicare patients to hospitals, the AMA said:

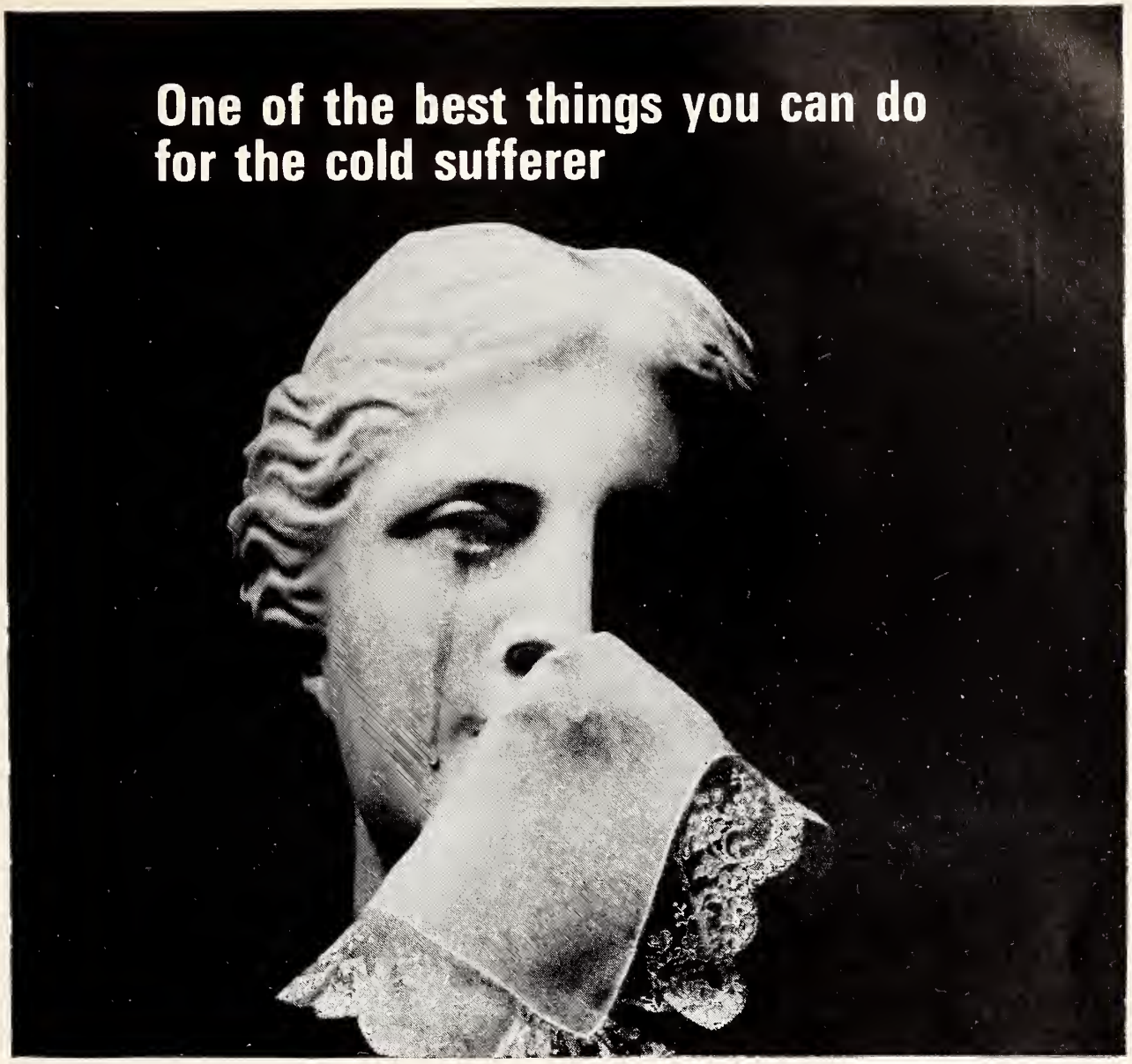
"AT THE PRESENT TIME a utilization review plan of an institution must provide for review, on a sample basis or other basis, of admissions, duration of stays, and services furnished but must provide for review of each case of extended stay and also determine medical necessity of further stay. The law provides for three additional days of benefit payments after a negative finding and notification.

"WHERE A FINDING has been made that the admission was unnecessary, no payment would be made. Thus the denial of payment would be retroactive to the date of admission. The three-day grace period is removed from existing law.

"THE AMA previously objected to initial certification of the need for admission to a hospital, and this initial certification requirement was removed from the law. Under this bill the utilization review committee would be required to review the attending physician's judgment as to the need for hospitalization. The present requirement of the committee under medicare is to review extended stay cases to determine need for further stay; thus it does not review a great number of cases of hospitalization where the patient is discharged earlier. Requiring committees to review all cases of hospitalization would impose a tremendous burden on the committee, and create additional heavy demands on physicians' productive manhours.

"AN ADVERSE FINDING by a committee would subject the patient to individual liability for hospital charges. As a result, this provision could act as a restraint on patients receiving care, particularly in those cases where a physician recognizes the possibility of differing medical judgments concerning the admission."

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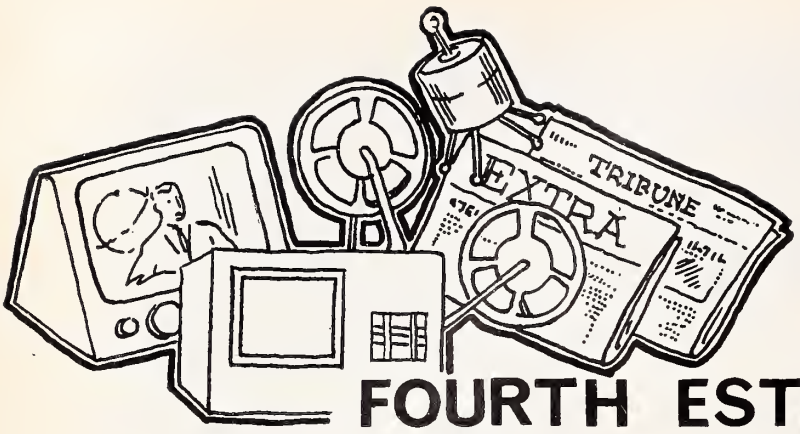
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Prompt relief from nasal congestion and hypersecretion due to colds.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
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Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.
Usage in Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.
Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.
Supplied: Bottles of 50 capsules.

One capsule q12h for round-the-clock relief

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FOURTH ESTATE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Abortion

Abortion in North America is "like an iceberg," says Dr. Edmund W. Overstreet, of the department of obstetrics and gynecology at the University of California School of Medicine.

Therapeutic or legal abortion (the small visible portion) is freely discussed, he says, but "the much larger and much more deadly portion of the iceberg (illegal or criminal abortion) still lies semiconcealed, scarcely touched by the advances of moddern science or the progress of modern society."

It doubtless came as a shocking surprise to thousands of Hammond citizens to read in *The Times* Sunday of an illegal abortion parlor flourishing three blocks from city hall. None know except the parlor's practitioner how many abortions he has performed.

Nationally, estimates of criminal abortions range from 300,000 to 2 million a year. Dr. Overstreet says that available information indicates that one out of every four or five pregnancies is interrupted by resort to illegal abortion and "this results in about 3,000 to 4,000 deaths annually."

Why do girls and women run the high risk of death, of disfigurement, of permanent sterility by using the services of an amateur "baby killer," few of whom have any kind of medical training or any concept of sterilization? The answer is a measure of their desperation. So long as this desperation exists, so will criminal abortionists.

Banning abortions hasn't solved the problem. In countries with such prohibitions, the illegal abortion rate is higher than where abortion is permissible under certain conditions. But in the latter circumstances, illegal abortions have not declined; indeed in Sweden they are on the rise.

Pregnancy is a personal matter. Terminating it is more so. Neither can be legislated into or out of existence, as experience shows. Perhaps, if we want the criminal abortion issue resolved, we should profit by that experience and let the question of abortion be resolved on an individual basis; let individual conscience be the guide, not laws.

But, until society makes a formal move to adopt that attitude — or some other — abortions are both illegal and grossly dangerous. The practice and the practitioners are from the bottom of the social cesspool and must be treated accordingly.—*Hammond Times*, Sept. 17, 1969.

Doctors Face Growing Threat

It is possible for a physician to lose a suit for malpractice and be assessed heavy damages even if he is in no way to blame. As a result, doctors are becoming shy of taking certain kinds of cases and insurance rates against malpractice are soaring.

In the country at large, the average for more than 7,000 doctors in malpractice premiums is about $5,000 a year. In Southern California, doctors who practice in high-risk specialties such as surgery and anesthesiology, pay $7,500 to $12,000 a year in premiums.

The Los Angeles County Medical Association is considering various protective measures. One is to ask patients to sign an agreement not to sue, before a doctor will take the case. Another is that the patient will abide by arbitration in case of a mishap. That would seem to protect both physicians and patients, without the risk of sympathetic juries assessing fantastic damages.—*Evansville Courier*, Oct. 2, 1969.

Doctors Are People Too

One great fault of government health care programs to date is failure to recognize that people are involved at both ends of the health care equation. On one end are those who need care and on the other are those who must provide the care — the nation's doctors. In the past, laws have been written creating health care programs with little consideration for the multitude of problems imposed by such programs on the medical profession. Although responsibility for making the programs work is laid at the doors of the doctors, medical men have gen-

erally been treated as a mere public utility by medical care planners.

Inflation has presented physicians with the same rising costs facing everyone else — a fact that should be kept in mind in seeking any solution to the problem of fees to be charged under medicare and medicaid. As an official of the American Medical Association points out, physicians' fees are not the major cause of spiraling medicaid expenditures, and the imposition of a fee ceiling on physicians only "is clearly discriminatory." The spokesman went on to warn, "Caution is needed lest any action which is taken may have a discouraging effect upon full scale participation in the medicaid programs." Recent charges in the rules governing fees may reach beyond congressional intent.

The medical profession is working wholeheartedly to make government health care programs work. Its voluntary cooperation will be greatly stimulated if government and the public recognize one practical fact — doctors are people too.—*Rushville Republican*, Sept. 25, 1969.

Should Consider Noblesville Plan

Riverview Hospital at Noblesville has instituted a weekend house physician program which might well be studied by persons interested in medical services here.

Under the program, six resident doctors from Indianapolis are staffing the hospital's emergency room from 6 p.m. Friday until 6 a.m. Monday to treat incoming patients. The program was set up to assist over-worked physicians of Noblesville and Hamilton County.

Prior to the house doctor program, the county's local doctors covered the emergency room seven days per week.

Incoming emergency patients may request treatment by their family physician or may be treated by house doctors.

The house doctor program was not initiated to take the place of family doctors in emergency treatment but rather to assist the local physicians.

The house doctors are full M.D.'s but are studying in a specialized area of medicine at Indiana University Medical Center in Indianapolis. They work 12 hours and are paid $100 per shift.

Patients are charged for the house doctor's services just as they would be if a local physician treated them. The fees charged have been approved by the emergency room committee and the executive committee of the hospital's medical staff.

During weekends, the Riverview Hospital's house doctors have been taking care of almost two-thirds of those requiring emergency treatment. They also work in the emergency room during holiday periods.—*Crawfordsville Journal & Review*, Oct. 14, 1969.

Alcoholism

Statements made before the Senate Alcoholism Study Committee made sense, but in reviewing them we recognized familiar words and phrases.

All of the sound advice offered has been heard before. In years past senators just as interested as those on this panel heard testimony, nodded, clucked their tongues and agreed that, yes, something really ought to be done about the way chronic drunks are treated.

Or mistreated.

Despite the rush to agreement not only by senators but also by representatives, county commissioners, aldermen, city councilmen and health officials, little has been changed.

Except statistics.

Drunk arrest rates go up. That's a change.

The cost of pushing chronic drunks through arrest, trial and jail continues to go up. That's a change.

The attitude that an alcoholic who presents himself to public view should be punished instead of medically and psychologically treated — now that hasn't changed.

Courts decide that it is unlawful under the Constitution to sentence an alcoholic to jail—but that is what we do here.

Medical men say that alcoholism is usually difficult to cure but that money, time, patience and professionals can often cure it. They do not say that throwing a drunk into the drunk tank at the jail is going to reclaim him as a useful, self-reliant citizen. No, they do not say that.

Too many Americans think that jail is the answer to all of the nation's ills. That is a primitive attitude and one reflecting a callous, inhumane view of the worth of human life.

Alcoholics who present themselves to public view must be protected and the community must be protected from them. But the place for them is a hospital not a cell. Until we provide such treatment, all of the talk before Senate committees is just so much gab.—*The Atlanta Journal.* ◄

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Supervised by THE COUNCIL
Volume 62 — December 1969 — Number 12

Depression and anxiety present in various proportions. Treatment of one necessitates treatment of the other.

The Shades of Green

GEORGE S. ALLEN, M.D.
Georgetown

THE classical picture of depression is well known to all of us. In the second century A.D., Plutarch wrote: "He looks on himself as a man whom the gods hate and pursue with their anger. A far worse lot is before him; he dares not employ any means of averting or of remedying the evil, lest he be found fighting against the gods. The physician, the consoling friend, are driven away. 'Leave me,' says the wretched man, 'me, the impious, the accursed, hated of the gods, to suffer my punishment.' He sits out of doors, wrapped in sackcloth or in filthy rags. Ever and anon he rolls himself, naked, in the dirt confessing about this and that sin. He has eaten or drunk something wrong; he has gone some way or other which the Divine Being did not approve of. The festivals in honor of the gods give no pleasure to him but fill him rather with fear and affright."[1] This vivid description of melancholy has yet to be surpassed. Such a patient is the prototype of depression—the prime candidate for electroconvulsive treatment. His mood is depressed and characteristically blue. He is the epitome of misery.

Anxiety can be simply defined as fear when the object of fear is unknown. The fight or flight apprehension is a subjective experience very well known to twentieth century man and is singularly uncomfortable in its alarming apprehension. Let us arbitrarily designate the alarm color yellow as its hallmark.

Admixture of Hues

Although the blue depression cases and the yellow anxiety panic states do occur in fairly pure form, the common, everyday situation seen by all practitioners is neither blue nor yellow but an admixture of both—the shades of green. These are the tired housewives, the pre-ulcer and ulcer cases, the worn-out young husbands, the headaches, backaches, genito-anal complainers (when no organic basis is to be found). These shades of green are the "crocks" and the "psychoneurotics" that permeate medical practice, both private and clinic. These shades of green are the greatest challenge any doctor can face.

The literature abounds with treatises and reports dealing with the fairly blue depressions. Such cases are commonly admitted to the neuropsychiatric hospitals. They are variously diagnosed as psychotic depression, involutional melancholy, depression reaction and endogenous depression. There is usually some degree of anxiety present in such cases of depression and also one ordinarily encounters a definite amount of somatic complaining. The overall picture, however, is one clearly of depression and to a superficial clinical point of view there is little similarity with the above-mentioned "crocks" and "psychoneurotics." Only a few papers[2,3] have appeared that call attention to the basic and underlying depressive pathology of these poor patients.

It has been variously estimated that upwards to 80% of the nonfebrile, non-injured adult patients seen by the average physician fall into this category. In all probability they are the most tested, most examined, most mismanaged and most migratory patients in any doc-

tor's practice. They are the source of more normal tissue in the surgical pan than any other group—they are the main line of support of the chiropractor and his cultist brethren. They constitute the stiffest exam any of us shall ever face in medicine.

It seems basic that a fundamental understanding of depression in terms of its psychodynamics is required if we are ever to cope successfully with the non-overt depressives—the "crocks"—the shades of green. As previously noted, Plutarch classically and admirably described the depressive, but it remained for Freud, Rado and others to explain the dynamics.[4] Depression always means the real or imagined loss of love or love object. The first time this occurs (and it occurs to all of us) is in infancy. The infant whose feeding is interrupted or delayed responds with the cry that is typical—the cry of rage, pure and simple. This response persists into early childhood when it can be beautifully recognized in the "temper tantrums" so disturbing to parents. The parents respond (sooner or later) by letting the small child know their disapproval either by the harrowed "Oh, dear God, not again" look or the more direct laying on of hands—usually posteriorly. One way or another, Junior or Sissy gets the message that temper fits displease Mommy and Daddy very much—rage, therefore, causes a loss of parental love and this begets an emotional response which Rado calls guilty fear.

Self-Punishment

The next step in the genesis of depression, therefore, is the pouting child. He looks more like depression. The child who pouts is unhappy and actually is punishing himself. Thus, Rado equated the dynamics of depression—rage evokes guilty fear and the guilt causes a retroflexion of the rage so that the individual punishes himself. All of this, of course, is at an unconscious level—the patient simply responds to the actual or imagined loss of love (or love object) in the manner which he first learned. Evidently this primary brain circuit takes over at this point and depression begins. Knowing the basic dynamics is obviously important to any form of treatment.

The retroflexion of rage doesn't always create the same clinical picture. The "blue" depression case is one way it can appear, but for every one such case there are probably several hundred in whom the self-punishment—the retroflexed rage—is expressed differently. The titre of anxiety probably is the major factor in the difference—just as the shade of green will depend upon the amount of yellow pigment added to the basic blue. Thus, it seems a reasonable analogy that the clinician's task with patients is like that of a keen artist—he must be able to appraise the amount of yellow and the amount of blue in a given shade of green.

It is important also for the clinician to realize that depression has a peculiar cyclic or undulating character. This can be best appreciated by getting a good history from the patient—most commonly such patient will relate previous episodes similar to the one of the present complaint.

Proper Treatment

The mention of history taking conveniently sets the stage for the all important business of treating these people. It was stated previously that such cases are very often mismanaged—it is regrettably true that chiropractic success is mute testimony to this mismanagement. How then should proper treatment be instituted? It would appear that the following format might merit consideration:

1. *Diagnosis:* Although these patients are much examined and much tested, a physician owes it to himself and to the patient to facilitate a work-up sufficient to rule out any etiologic organic pathology. It is well to realize that a detailed physical examination and the taking of a good history have a most valuable psychotherapeutic role.

2. *Time:* These patients require far more time than do the organic illnesses. This expenditure of the physician's time must certainly be made in a warm and understanding manner on the occasion of taking the history and the time investment must be repeated on follow-up visits. For these patients to gain insight to their disorder they must have a positive, trusting relationship with the doctor and the investment of time by that doctor predicates such trust.

3. *Medication:* These "green" cases need medicine yet they should be made aware that the medication alone will not make them well. A patient understands the steps in the treatment of a broken arm. The physician first must diagnose the fracture, then set it. This usually causes some pain but when the bones are in alignment the cast is applied, the pain stops and the bones start the healing process. Patients understand that the cast doesn't heal the bones but the bones heal themselves in the protective environment of the cast. These patients will, then, understand that medications used for depression are like chemical casts applied for broken emotions. Such an explanation sensibly motivates the patient to take the medicine and at the same time to realize he must help himself. The choice of medication is most important in treating the shades of green. All too commonly the anxiety present seems to dominate the physician's attention and he prescribes any one of the myraid of tranquilizers— the anxiety component of illness responds and the depression becomes abundantly manifest. Unfortunately it can deepen. If one realizes that the anxiety is present basically as a kind of defense mechanism to the depression, it seems

ogical to expect the anxiety to dissipate as the depression fades. This, n fact, is exactly what happens and herefore treatment with tranquilizing nedications having no antidepressant ctivity should be avoided.

In my own personal experience, ery satisfactory and gratifying results have been achieved with desipramine in dosages varying from 25mg to 50mg three or four times laily. It appears that the latency period of despriamine is definitely shorter than it is with imipramine or amitriptyline—the antidepressant effect has been evident in one week n the vast majority of my patients.

Other medications can be used in he treatment of the "shades of green." Some of these are amphetamines and methylphenidate. In many cases satisfactory results can be achieved especially with the latter, but the duration of therapeutic effect doesn't seem as predictable to me as with desipramine. Actually the interest of the physician and his bona fide attention to these patients is the basic ingredient of the "cure potion."

Summary

In summary, attention has been called to a vast array of patients that are often labeled neurotics and other rather uncomplimentary descriptive terms. These patients are very migratory and most challenging. The underlying basic depressive psychopathology has been noted and its admixture with anxiety briefly outlined. Hopefully, the analogy of depression and anxiety with the colors blue and yellow might help make many of the patients we know more understandable and thus more treatable.

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*"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.

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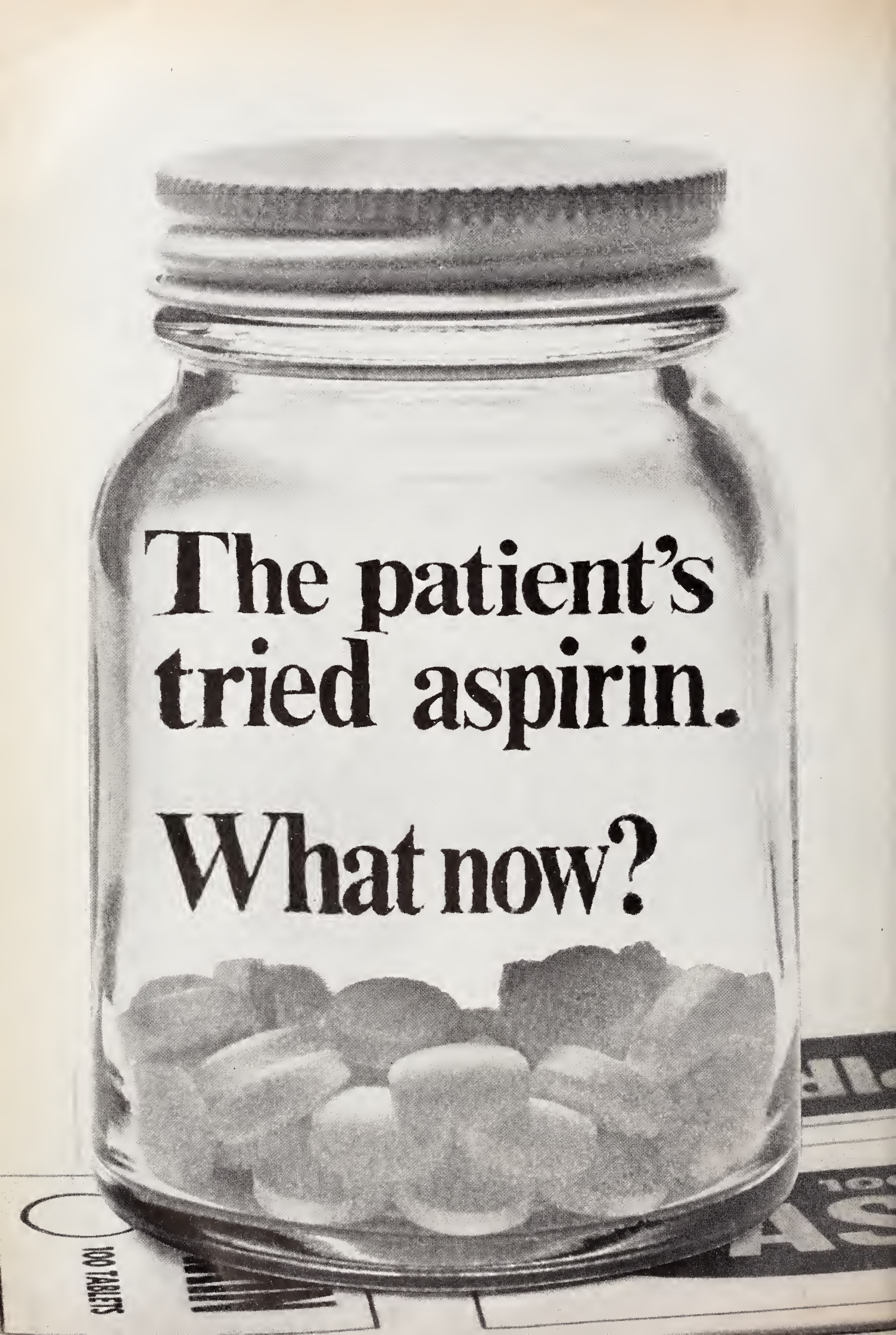
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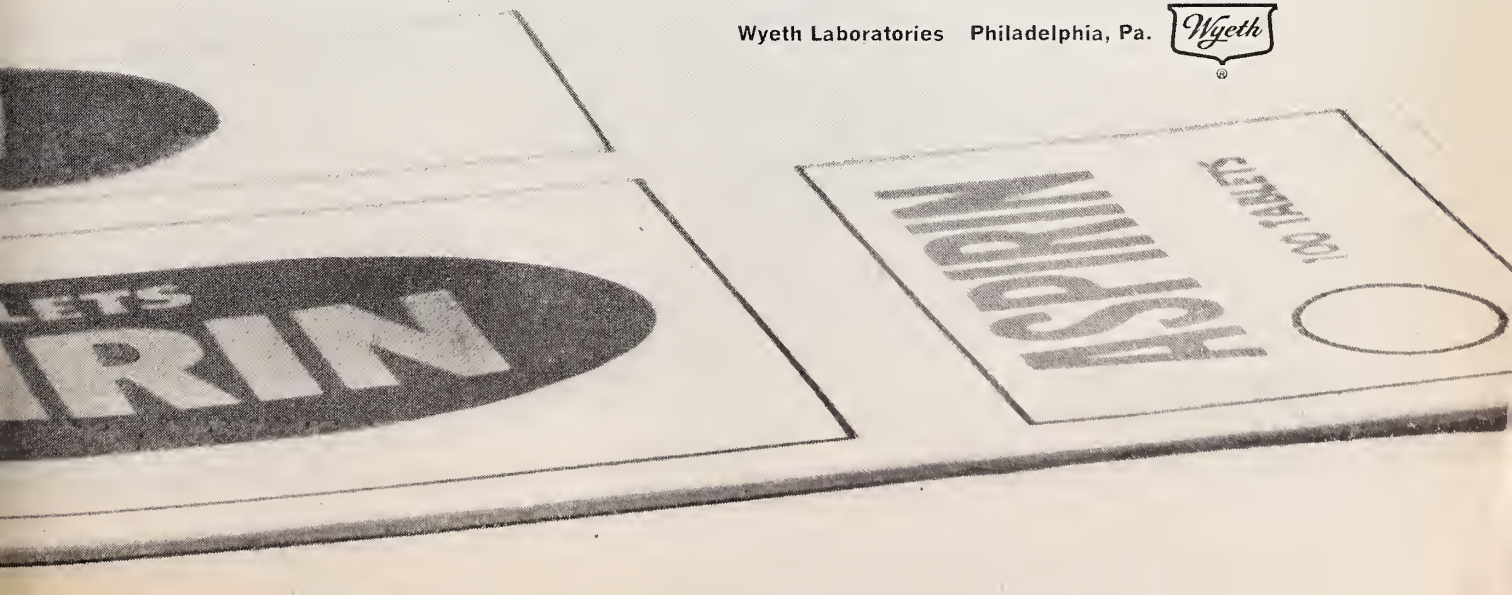
Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

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Primary Malignant Tumor of the Jejunum

B. T. MAXAM, M.D.
Indianapolis

PRIMARY malignant neoplasms of the small intestine are so uncommon that the diagnosis is most often made by exclusion. Malignant lesions of the small bowel constitute about five percent to six percent of all gastrointestinal tumors and about one percent to 22% of all malignancies.[1] The death rate caused by these lesions is higher than from tumors involving any other portion of the gastrointestinal tract. Survival rates for adenocarcinoma of the small intestine have been reported to be from 5%[2] to 22%.[3] The delay in diagnosis and treatment is responsible for this mortality rate.

Case Report: A 73-year-old, white male executive was admitted to the St. Vincent's Hospital in Indianapolis on November 6, 1963, because of recurrent bouts of abdominal pain. He presented himself to my office around the 1st of October, 1963, because of recurrent vague discomfort in the mid-abdomen. He noted that eating salads or fresh fruits would result in the passage of one to three loose stools per day without the presence of blood or mucus. This would occur without warning. On occasion, he stated, he had an episode of nausea and on one or two occasions had vomited.

In June, 1963, he developed a rather severe mid-abdominal pain, consulted a physician who gave him paregoric and the situation gradually subsided. He noted that his appetite had not been quite as good as it had been in the past. Shortly before I saw him in the office, he began to have attacks of severe periumbilical cramping. On one or two occasions this cramping became quite severe and was associated with vomiting and distention of the abdomen. A few hours later, the situation would be relieved by the passage of liquid stool and a great deal of gas. There was no weight loss. Other than the recurrent attacks of periumbilical pain and abdominal distention, he felt well.

His past history was significant in that in 1957 a benign polyp was removed from the junction of the descending and sigmoid colon. Otherwise, he had always been in excellent health. One brother died of "carcinomatosis."

Physical examination disclosed a well-developed, well-nourished patient who appeared much younger than his stated age of 73 years. His color was quite good. His pupils were round and equal, reacted to light and on accommodation, and the disks were normal. Slight A-V nicking was evident. Examination of the ears and throat revealed no abnormalities. No cervical, axillary or inguinal adenopathy was noted. The lungs aerated well without rales. The heart was not enlarged to percussion and was free of murmurs. The rhythm and rate were regular. The blood pressure was 170/80. The liver and spleen were not felt. The abdomen was soft and free of masses. The patient did complain of tenderness to the right and below the umbilicus. Rectal examination disclosed a slightly enlarged but soft prostate gland. No rectal masses were detected. Sigmoidoscopic examination to 18 cm. failed to reveal any abnormalities. The femoral, posterior tibial and dorsalis pedis pulses were full and equal, and no neurological abnormality was detected.

Laboratory Findings:

C.B.C.: Hgb: 10gms; Htc: 30 vols %; W.B.C.: 13,050; Polys: 72; Lymphs: 28.

Urinalysis: Sp. grav.: 1.006; Sugar: negative; Albumin: negative; Micro: 5-6 WBC's per H.P.F. and 3-4 RBC's per H.P.F.

Total Protein: 5.9 gms/100ml, 3.7 albumin and 2.2 globulin

Electrophoretic Pattern: Revealed very slight elevation of alpha-2 globulin

B.S.P.: 3.9% dye retention

Serum Alkaline Phosphatase: 3.4 Bodansky units

Thymol Turbidity: 3 units

S.G.O.T.: 15 units

B.U.N.: 12.5 mgms%

Serum Amylase: 157 units

Cholesterol: 182 mgms%

Examination of the stool for occult blood inadvertently was not carried out.

PA and lateral films of the chest revealed finely nodular, diffuse changes in both lungs, most likely representing interstitial fibrosis. The heart measured 126 mm. in transverse diameter, against a standard of 123 mm. There was some calcium in the

descending aorta, and the aorta was slightly unfolded. A cholecystogram showed rather poor concentration of the contrast material in the gallbladder. Following the fatty meal, there was some contraction of the gallbladder, but no stones were recognized. It was felt that the degree of visualization of the gallbladder was substandard. A barium enema revealed no evidence of ulceration or obstructive change and no evidence of any polyps. An upper gastrointestinal series revealed a prominent esophageal ampulla and some slight deformity in the distal portion of the duodenal cap. A small bowel series was done on two occasions. Initially, transit of the barium through the small bowel suggested hypermotility. At 15 minutes, the head of the barium column was well into the ileum. However, on follow-up films, it was noted that the barium had not yet entered the colon up to one hour and 45 minutes, and there appeared to be some slight increase in the caliber of the distal jejunum and ileum. No evidence of any ulcerative lesion or any area of stenosis or narrowing was noted.



FIGURE 1
SECTION of the jejunum showing annular constricting carcinoma. The proximal jejunum is dilated.

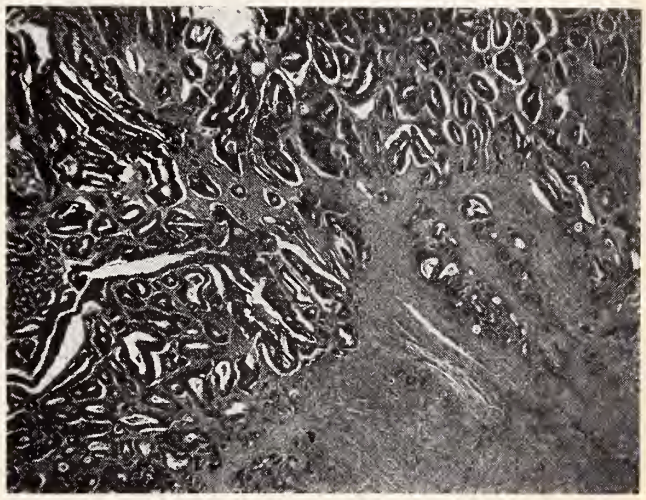


FIGURE 2
ADENOCARCINOMA of jejunum—numerous irregular anaplastic glands lying in submucosa with invasion through inner muscular layer (H & E X 30).

Because of the historical and clinical evidence of recurrent partial small bowel obstruction, and the peculiar pattern displayed by the small bowel series abdominal exploration was recommended and accepted. A right rectus incision was made and the small bowel was examined throughout its length. Numerous, freely-movable lymph nodes were found in the mesentery. High in the jejunum, about 19 to 20 inches from the ligament of Trietz, there was a constricting lesion. About one foot of jejunum was removed with the constricting lesion. The jejunum was repaired with an end-to-end anastomosis. A few of the mesenteric glands, not included in the specimen, were removed for pathological study. The lesion appeared grossly to be an annular constricting carcinoma of the jejunum (Figure 1). The microscopic pathological examination revealed it to be an adenocarcinoma (Figure 2).

Approximately eight months following the initial surgery, the patient had a recurrent small bowel obstruction. Re-exploration revealed an obstruction at the site of the anastomosis due to an adhesive band, and there was no evidence of recurrence of tumor. In December, 1966, the patient experienced a cerebral thrombosis with a right hemiplegia and aphasia. He was hospitalized for a period of time, and our examination again failed to reveal the presence of any recurrence of the tumor. The patient has made a remarkable recovery following this episode, and is doing well at the present time.

Discussion

Primary malignant tumors of the jejunum and ileum are not common. Dorman and Floyd et al.[4] found only 60 cases of primary malignant neoplasms of the small bowel in the files of the Charity Hospital in New Orleans during a period when there were 981,839 admissions. Rochlin and Longmire[5] found only 650 cases reported in a series from 1920 to 1960. They occur frequently enough, however, to be a diagnostic possibility in any patient with gastrointestional complaints.

The physician should be "small bowel conscious" when confronted by a patient complaining of symptoms of chronic abdominal pain, weight loss, intermittent obstruction, and the presence of occult blood in the stools. The infrequency of this problem usually leads the physician to find this lesion during the course of abdominal exploration or at the autopsy table. A preoperative diagnosis was made in only eight patients of 650 cases reviewed by Rochlin and Longmire.[5] Many symptoms of a less prominent nature are often overlooked, and this, combined with

the relatively short duration of symptoms (from about five to 17 months), leads to the continued poor prognosis in these patients. A preoperative diagnosis was made in only eight patients of Dorman's series,[4] and only 27 of the 49 patients who came to surgery were considered potentially curable. Adenocarcinoma is reported by some to be the most common primary malignant tumor in the small bowel,[6] and is also the most frequent cause of clinical signs and symptoms.[7] Adenocarcinoma occurs more often in the upper portion of the small bowel.[1] The majority of patients are over the age of 50 years, the average being 59.6 years in Hampole's series[8] and 70 to 80 years according to Ostermiller et al.[1] and Dorman.[4]

Most authors agree that the chance of an accurate diagnosis by x-ray decreases as the distance of the lesion in the small bowel increases. Sawyer et al.[9] state that x-ray studies are responsible for all diagnoses in duodenal tumors and lead to the diagnosis in about one-half of jejunal and ileal tumors. If the early diagnosis can be made, resection of the growth should be attempted. However, the surgical procedure carried out depends on the clinical state at the time of surgery. Pagtalunan et al.[3] found palliative procedures feasible in only 23% of 327 cases.

Conclusion

A case of primary malignancy of the jejunum and a review of the literature is presented. A high degree of suspicion of this lesion cannot be overly stressed.

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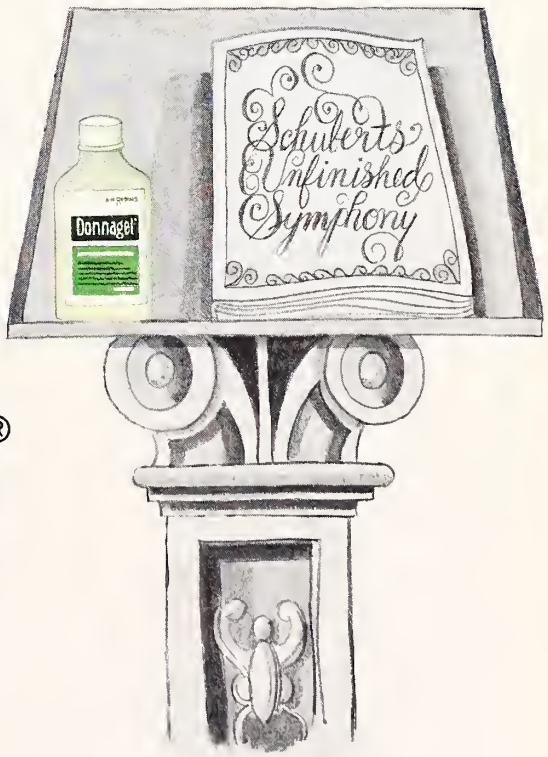
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Stenosing Non-Peptic Esophagitis

JACOB K. BERMAN, M.D.
GEORGE A. ROWE, M.D.
WILLIAM M. WAYMIRE, M.D.
Indianapolis*

THE purpose of this paper is to report two unusual cases of non-peptic esophagitis with obstruction. In a recent survey of the literature on diseases and injuries of the esophagus we found descriptions of only five similar cases.[23,27]

Final diagnosis was established through thoracotomy and full thickness biopsy.

Treatment consisted of esophagotomy without the need for organ transplantation.

Case Reports

Case No. 1: The patient was a 55-year-old carpenter. We saw him for the first time in January, 1967, because of a perforated duodenal ulcer which we closed without additional gastric surgery. He did well postoperatively and was discharged from the hospital on the sixth day.

Four months later (May, 1967) he was readmitted because of progressive dysphagia and vomiting of undigested food. The patient had lost 20 pounds in weight. Physical examination showed a thin man (130 pounds) who complained of much substernal distress. The pain was constant but more severe after swallowing any food, even liquids.

A complete blood count, urine analysis, VDRL, blood urea nitrogen and blood sugar were all normal. His total serum proteins, entire liver profile, electrocardiogram and chest x-ray examinations were also normal. An esophagram showed a "markedly stenotic lesion at the level of the carina having the appearance of an irregularly ulcerated carcinoma; the distal esophagus was normal" (Figure 1).

On esophagoscopy an obstruction of the mid-esophagus was seen which appeared to be carcinoma. The tissue obtained was examined microscopically and showed scarred epithelium. A pH electrode introduced under fluoroscopic guidance showed readings of 6.2 and 6. respectively in the upper and middle esophagus and 5.9 in the distal portion; there was no drop in pH on Valsalva maneuver. The gastric pH was 1.5.

A stricture of the mid-esophagus 3 centimeters long was identified on right thoracotomy, and tissue from this area was submitted for frozen section study. This was reported to be chronic inflammation with no gastric glands present. We performed esophagoplasty over a #40 Hurst dilator. The postoperative course was complicated by an empyema which required tube drainage. Dr. Lester H. Hoyt, pathologist at Methodist, concluded his report as follows: "Sections through the full thickness of the esophagus showed muscularis. The bundles of muscles show extensive infiltration of inflammatory cells between them. All types of cells are seen but principally neutrophils, many eosinophils, but the majority were small round cells. No definite ulceration can be identified because there is no mucosa in the specimen" (Figure 2). The eosinophils in this case may suggest an allergic response.

Following surgery we dilated the esophagus with Mahoney and Hurst mercury filled dilators up to #40, which the patient now uses at intervals. We prescribed phenergan 25 mg. daily to inhibit fibroplasia.[7]

Case No. 2: This patient was a 59-year-old male schoolteacher who was admitted to the Methodist Hospital for the second time in February of 1968. He gave a seven year history of pain, retrosternal burning and regurgitation. These symptoms became worse despite an intense medical regimen. Later he developed progressive dysphagia. This prompted his first admission which was in November of 1967 (Figure 3). Esophagrams showed achalasia with mega-esophagus. He also had a hiatus hernia and diverticulosis coli. The cholecystogram was normal.

A "balanced procedure" for the repair of hiatus hernia was done transabdominally,[4,6] with apparently good results. However, after about

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FIGURE 1
ESOPHAGRAM showing markedly stenotic lesion at the level of the carina having the appearance of an irregularly ulcerated carcinoma.

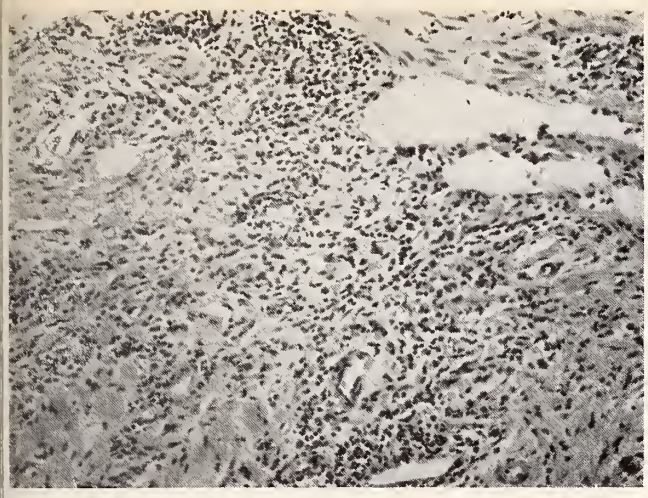


FIGURE 2
PHOTOMICROGRAPH x 100 from biopsy taken at the time of thoracotomy. The bundles of muscle show extensive infiltration with inflammatory cells between them. There are many eosinophils and neutrophils but mostly small round cells.



FIGURE 3
BARIUM swallow showing mega-esophagus with almost complete obstruction at the cardio-esophageal juncture, secondary to hiatal hernia with erosive esophagitis.



FIGURE 4
BARIUM swallow showing marked dilatation of the esophagus with an area of stenosis at the level of the mid-esophagus.

three months, his dysphagia recurred and he had lost 40 pounds in weight.

Physical examination showed no gross abnormalities and the old right paramedian incision had healed by first intention. His laboratory studies included a complete blood count, urine analysis, blood sugar and electrolytes, all of which were normal. His VDRL was negative. He had a slight elevation in his blood urea nitrogen (28 mg.%). A chest x-ray and electrocardiogram were normal. Esophagrams showed great dilatation of the esophagus with an area of stenosis at the level of the mid-esophagus (Figure 4). Studies with an esophageal probe above, within and below the stenosis showed a pH of 6.85, 6.84 and 6.22, respectively. We performed a left thoracotomy in February of 1968, at which time esophagoplasty was done over a #40 Hurst dilator. The esophagus was sutured longitudinally as had been done in the previous case. Esophageal biopsy and regional nodes showed a granulomatous inflammatory infiltration. The following quotation is from Dr. Lester H. Hoyt's report:

"Sections through the esophagus including several pieces of tissue reveal a granulomatous inflammatory infiltration which involves all of the mucosa, a major portion of the muscularis, and some of the surrounding areolar tissue. We also see fibrous tissue proliferation with a considerable number of interspersed small round cells and a large number of giant cells. The giant cells are of considerable size and they resemble those seen in acid fast bacillus infections (Figure 5). But special studies for acid fast bacilli and fungi are all negative. Examination of the slides with polarized light failed to reveal any foreign body. We are left without an explanation of the etiology of the granulomatous process. Examination of the regional lymph node revealed it to be markedly hyperplastic and again to be infiltrated with granulomas similar to those described above (Figure 6). Some brown granular pigment is seen in these cells.

"Final diagnosis: granulomatous esophagitis, non-specific, hyperplasia and granuloma of regional lymph nodes."

The patient has swallowed without difficulty since surgery and he has now learned to dilate his esophagus as needed. As in the previous case, we prescribed phenergan 25 mg. daily. The patient has regained his weight loss, and a recent x-ray examination showed no narrowing of the esophagus.

Discussion

Inflammations of the esophagus are common [1,20,21,22,25] and their causes are manifold and multifarious.[2,10,15,16,21,23,26] The ordinary and frequent reasons for esophagitis are described as acute erosive, due to trauma (mechanical or chemical) of any kind, and chronic progressive erosive, which may be due to hyperchlorhydria,[1,3,13,19,25] and which may occur as high as the aortic arch,[3,14,26] or sometimes achlorhydria with atrophic epithelium.[20,24] Also, infection by bacteria and viruses[11,12,23] may cause esophageal inflammations with or without stomatitis. Congenital anomalies are seen occasionally in the adult[8,9,17] and may cause constrictions. Systemic diseases[5,18] are frequently associated with mor-

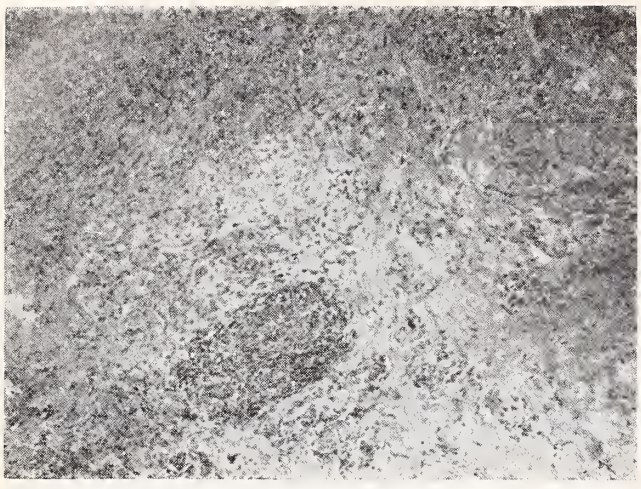


FIGURE 5
PHOTOMICROGRAPH x 100 from biopsy taken at thoracotomy showing granulomatous inflammatory infiltration.



FIGURE 6
PHOTOMICROGRAPH x 500. Regional lymph node infiltrated with granulomas as described in Figure 5. Some brown granular pigment is present. Note the large number of giant cells.

bid changes in the esophagus[10] including episodic bleeding (Cushing's ulcer). Finally, there is a group of esophageal ulcerations which may be termed idiopathic and which include the two cases herein reported.

Summary

We have operated upon two cases of non-peptic esophagitis. The lesions appeared grossly similar to Crohn's disease as seen in other portions of the alimentary canal, such as regional enteritis, terminal ileitis and regional colitis.

The cause is unknown and tests made with a pH meter failed to show increased acidity in, above, or below the involved area in our two patients.

The possible relationship to sarcoidosis is suggested by the microscopic picture but as in non-specific regional enteritis this possibility is now held to be untenable.

Treatment consisted of transthoracic esophagoplasty to obtain adequate specimens for biopsy and to relieve the stenosis thereby restoring the swallowing function. This was accomplished without radical resection or organ transplantation.

Our patients were advised to take phenergan daily to help impede fibroplasia.

Acknowledgments

Lester H. Hoyt, M.D., and Paul Evans, M.D., from the Department of Pathology, Methodist Hospital, helped us select representative sections for this report.

Mr. J. F. Glore, Department of Medical Illustrations, Indiana University Medical Center, made the photomicrographs.

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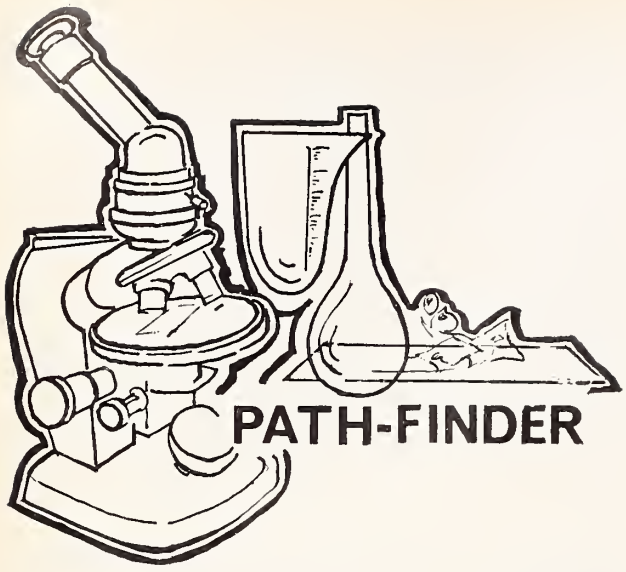
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This series is intended to emphasize the importance of judicious selection and proper interpretation of newer laboratory procedures as applied to differential diagnosis of various diseases. It is edited by Leon L. Blum, M.D., Terre Haute.

Antibiotic Sensitivity Testing[*]

ANTIBIOTIC sensitivity testing is a widespread practice, and when properly performed by knowledgeable and experienced laboratory personnel, it can be of marked significance to the physician in determining the therapeutic course to follow in an infectious process. Two methods of testing are currently used. In each of these methods the pathogenic organism must be isolated and identified from the specimen submitted to the laboratory.

The disc sensitivity test is a method wherein commercially produced filter paper discs containing a known level of antibiotic are placed on the surface of an agar plate that previously has been seeded with the organism under test. After overnight incubation, zones of bacterial inhibition are seen around the discs containing those antibiotics to which the organism is sensitive. Discs containing antibiotics to which the organism is resistant will not inhibit growth. Reports to the physician of the results of this type of testing should be as uncomplicated as possible, indicating that the organism is either sensitive or resistant to the antibiotic. On the basis of the disc sensitivity, one cannot infer the degree of bacterial susceptibility or resistance.

The rapid hemoglobin-reduction sensitivity test is a modification of the disc method. Sheep red cells, as well as the organism being tested, are incorporated in the agar. The test results are determined by the appearance or absence of reduced hemoglobin within the red cells around the sensitivity disc—the rationale of the test being that organisms adjacent to the discs containing antibiotics to which they are resistant will continue their metabolic processes and will utilize the available oxygen from the red cells. This oxygen utilization will result in the reduction of red cell hemoglobin and is detected by a darkening of red cells around the disc. Discs that contain antibiotics to which the organism is sensitive will inhibit bacterial metabolism and the red cells around these discs will retain their bright red color. Since this test is based on bacterial metabolism and not on visible bacterial growth, the results are available in two to three hours rather than after overnight incubation. The rapid method is most helpful in life-threatening infections such as meningitis and septicemia because the antibiotic sensitivity pattern of the infecting organism is known before the patient's response to any antibacterial therapy is evident.

The tube-dilution method of sensitivity testing is less widely used than the disc method. In this procedure, dilutions of the antibiotic are made in tubes of appropriate growth medium. The tubes are inoculated with the organism under test, and after incubation are inspected for bacterial growth. The results of the tube-dilution method are reported as the least inhibitory concentration of antibiotic. The assumption is, for example, that if 0.5 unit of an antibiotic is inhibitory *in vitro* and if this same blood level of antibiotic is obtainable following a therapeutic dose, the drug's use is indicated.

In comparing the usefulness and reliability of the two methods, it can only be said that the proponents of the tube-dilution method are firm in their convictions that the recommendation of a specific antibiotic can only be made when the inhibitory level of the antibiotic is known and when this level can be obtained or exceeded in the circulation. However,

[*] Prepared by the Section of Practice of Pathology in the Private Office, College of American Pathologists.

the tube-dilution method is a comparatively expensive test and the number of antibiotics that may be tested is limited since each antibiotic constitutes a different test. The disc method, although less quantitative, affords a relatively inexpensive method of determining the sensitivity pattern of an organism to a number of antibiotics, possibly eight to ten, within the same test.

Empirical evidence from countless tests over a number of years has validated the effectiveness of the disc method. Thus, the disc method of sensitivity testing is reliable when its shortcomings are understood by the laboratory personnel and the physician. The enteric bacteria are notorious for giving false-negative reactions to sensitivity tests to the sulfa derivatives; that is, the test frequently indicates that the drug is ineffective while the patient quickly responds to specific therapy. This happens frequently in urinary tract infections.

Mixed sensitivities: The practice of using the specimen as the inoculum for sensitivity testing has some merit when judiciously applied. This is particularly true for specimens from the throat, nasopharynx, and infected wounds. When performed by experienced personnel the sensitivity pattern of a pathogenic organism can be determined from a sensitivity plate containing several unimportant contaminants. Mixed sensitivities can be condoned only in those cases in which the laboratory will repeat the studies on isolated organisms when the first test results are not absolutely clear. Mixed sensitivities are of no value in grossly contaminated specimens such as stool specimens or where overgrowth by a highly motile organism occurs. The rapid hemoglobin-reduction and tube dilution methods are not suitable in determining mixed sensitivities because the result obtained by either of these methods is only the sensitivity pattern of the fastest growing organism in the contaminated specimen and not necessarily that of the pathogen.

In the past few years, numerous antibiotic test kits have been commerically produced to provide sensitivity testing as an office procedure. This type of sensitivity testing has been found to be inaccurate for the following reasons:

1. *Overgrowth by contaminating nonpathogenic organisms.*
2. *Lack of stability of various antibiotics contained in the test kit.*
3. *Unreliability of the growth medium in the kit. Fastidious pathogenic organisms failed to grow.*
4. *The test results were not reproducible.*
5. *There were no means provided to identify the organism whose sensitivity pattern was determined.*

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ELECTROCARDIOGRAM OF THE MONTH

Atropine in Myocardial Infarction

CHARLES FISCH, M.D.
*Indianapolis**

THE slow rhythms associated with myocardial infarction can, as a rule, be ascribed to disturbances of SA function or A-V conduction. Both, especially when complicating inferior infarction, may be the result of intense vagal stimulation and would therefore respond to atropine. Not infrequently, slow rhythms predispose to ventricular arrhythmias or ventricular standstill and should therefore be controlled whenever possible.

An example of marked sinus bradycardia with secondary junctional (A-V nodal) escape rhythm responding to atropine is shown in the accompanying figure. The top row (Leads II, III) demonstrate an acute inferior infarction. A tracing recorded at 8:45 A.M. (row 2) shows sinus bradycardia at a rate of about 50 with an escape rhythm originating in the A-V junction. The ECG at 9:30 A.M. (row 3) demonstrates the sinus bradycardia with a P-R of .20 seconds. At that point 1.25 mg. of atropine was administered intravenously and within less than 30 seconds the sinus rate increased to 100 with a normal A-V conduction. ◄

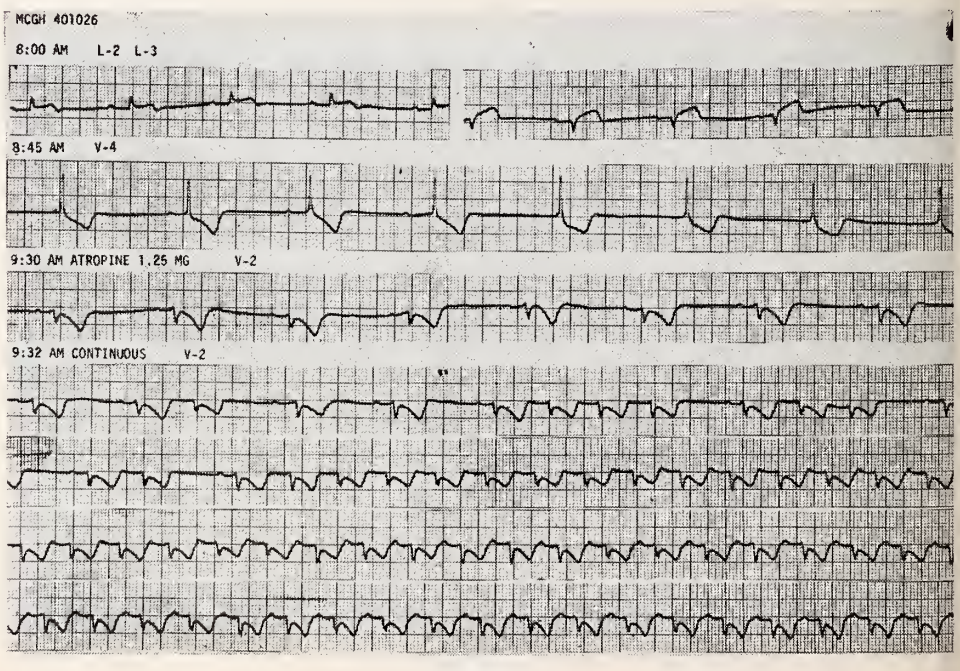


FIGURE 1
ACUTE inferior myocardial infarction with sinus bradycardia and A-V nodal (junctional) escape rhythm treated with atropine.

* From the Krannert Institute of Cardiology, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.



Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic/antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

PRECAUTIONS: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and toler-

or here.



d). Though generally not recommended, if nbination therapy with other psychotropics ms indicated, carefully consider individual ırmacologic effects, particularly in use of po- tiating drugs such as MAO inhibitors and enothiazines. Observe usual precautions in sence of impaired renal or hepatic function. radoxical reactions (*e.g.*, excitement, stimula- n and acute rage) have been reported in psy- atric patients. Employ usual precautions in atment of anxiety states with evidence of im- ıding depression; suicidal tendencies may be sent and protective measures necessary. Vari- e effects on blood coagulation have been orted very rarely in patients receiving the ıg and oral anticoagulants; causal relation- p has not been established clinically.

ADVERSE REACTIONS: No side effects or nifestations not seen with either compound ne have been reported with Librax. When ordiazepoxide hydrochloride is used alone, owsiness, ataxia and confusion may occur, ecially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

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Experience has shown that Terramycin offers special advantages in treating urinary tract infections when strains of causative bacteria are susceptible. Broad-spectrum coverage unaffected by penicillinase. Effective tissue levels to help reach foci of infection in renal parenchyma. High urine levels—excreted by kidney in *active* form.

With Terramycin, you have the assurance that comes with choosing an agent physicians have depended on for over 18 years. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Contraindicated: In individuals hypersensitive to oxytetracycline.

Warnings: Reduce usual oral dosage and consider antibiotic serum level determinations in patients with impaired renal function.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight; if such reactions occur, discontinue therapy.

Note: With oxytetracycline, phototoxicity is unknown and photoallergy very rare.

Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy. Increased intracranial pressure in infants is a possibility. Symptoms disappear upon discontinuation of therapy.

Adverse Reactions: Nausea, diarrhea, glossitis, stomatitis, proctitis, vaginitis and dermatitis, as well as reactions of an allergic nature, may occur but are rare.

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*All potencies listed are in terms of the standard, oxytetracycline.

More detailed professional information available on request.



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Devoted to the interests of the medical profession of Indiana

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Medical Care Cost Escalator

MEDICAL care costs and especially hospital costs are high and are going higher. This was the gist of the discussion at the National Pharmaceutical Council Symposium in Washington recently.

Mr. Ray E. Brown, formerly with the American Hospital Association and now Professor of Administration at Harvard University, was the moderator of the symposium and represented the hospital segment of the presentation. He opened the meeting by saying that the rate of increase in health care expense is exceeded only by the concern which has been generated about it.

Mr. Brown thinks many factors have coincided to highlight the problem and to frustrate its solution. Collective payment plans have consolidated the costs and made the problem more visible. The war against poverty and the Vietnam War have constituted unusual demands on public funds with a reciprocal decrease in resources for medical care.

In addition, inflation has robbed the health budget of some of its wealth. These factors, together with the fact that the public's aspirations for health have been overbuilt, and the growing realization that money won't do everything, have complicated the proceedings. There has also appeared an ideological conflict with the voluntary system—a conflict which has been verbalized by a small but knowledgeable and vocal segment of the population.

Professor Brown is sure that the costs will continue to increase. In the past five years the nation has gone from an expenditure of $33.6 billion, (5.2% of the gross national product) to $55.5 million, 6.3% of the GNP. By 1975 he expects the bill to be $94 billion or 7.5% of the GNP.

Change, he says, if there is to be any, must be made in the health care system. It is not possible for individual institutions to reform individually.

One method, Mr. Brown suggests, to limit hospital costs is to limit the supply. There is practically no limit to the utilization of acute care beds if they are built without limit. The biggest need now is for convalescent, limited care, and nursing home facilities. He suggests the possibility of public control of the number of hospitals and nursing home beds by a franchise system similar to that which regulates the establishment of banks.

In addition, utilization control can be improved. There are regional differences in the length of hospital stay for common conditions which amount to as much as 100% variation. These are average figures for uncomplicated cases. One region in the U.S. uses twice as many hospital days for obstetrical cases as another, both with excellent results. Uniformity, presumably by shortening the customary stay in some regions, will lower the hospital bill.

Mr. Brown emphasizes that labor costs are the biggest part of hospital expenses. Unionization will increase hospital wages and raise the health care bill. However the type of annual statewide bargaining of wage rates, as is done in Minnesota, will provide a method by which the public may help decide the wage question.

Medical institutions will save money—as much as $500 million annually for the nation—by giving up item-posting in their bookkeeping. Most hospital expenses are prepaid by standard premiums, the size of which is determined by averaging. Hospitals may fairly determine an individual patient's bill by the average method and charge an average daily rate, regardless of the number of hypodermics, dressings, laboratory tests, x-rays or intravenouses, and regain for the total number of patients the same amount of money they receive now by itemizing the accounts. Charging by average is as equitable as paying insurance premiums by the average.

Mr. Brown refers to the above mentioned $500 million as money which is a part of the annual medical

care bill but which does not represent any part of the medical service. Another item in the same classification is the money it costs to keep books on co-insurance and deductibles.

Both of these insurance principles, says Mr. Brown, are desirable, since they serve to limit utilization and total expenditures. However, since the effect of co-insurance and deductible payments can be averaged, there is no need to keep books specifically on each individual patient to obtain the same effect. A set percentage may be determined to approximate and represent the effect of both co-insurance and deductibles. In the bookkeeping department this standard percentage deduction can be applied to all parts of the bill with a very simple bookkeeping procedure. The annual savings which would accrue from this one charge is variously estimated as between $700 million and $1,100 million.

In closing, Mr. Brown stated that, in the interests of brevity his remarks had necessarily been condensed, but that he would amplify his presentation in printed form and that the proceedings of the symposium would be offered later for publication.

Guest Editorials

New Monthly Feature

THE inauguration of the monthly feature entitled "Lounge Talk" is a further attempt to increase the discourse between the leadership and general membership within ISMA. We hope it will innovate an effective means whereby the wishes of the membership will have a sounding board for the thoughtful considerations of our leaders. Heretofore, most of the avenues of communication have been from the top level, funneling down to the grass-roots members and the latter have seemingly had to use back alleys and rear doors to exchange views with our leaders.

Being somewhat of a "maverick", I can honestly state that this situation has not been created by design on the part of our leaders. In spite of many divergent viewpoints, I have always been received kindly and politely by the leadership ever since I became a delegate some ten years ago. In fact, through tenacious determination to fight for certain changes which our small county considers vital, I have been able to bring about such changes. It is with pride that I answer to the name of "Roll Call Hill" even though many have intended this to be derogatory.

It is fallacious to assume that our organization is run by an iron-fisted "elite few." This organization is the property of all of us. While time is running out (or has it already?), whether you approve of its actions or not, none has suggested better alternatives to fight the socialist enemy as it concerns medical practice today than through organized medicine. If the policies of organized medicine thus far have not met with your approval, the most likely reason is that too many of us have remained silent too long when these policies were decided upon by representatives whom you continue to elect to office.

I will endeavor to be caustic where needed—complimentary where deserved—and honest in all things concerning the attitudes and beliefs of our grass-roots members. I will be an ombudsman in the sense of imparting to our leaders what is held to be truth among our general membership, thus enabling our leaders effectively to fulfill the duties of their offices.

Your comments and opinions are not only welcome but requested by me in the preparation of this feature. The clarion call has been sounded—our members should respond.—**Lloyd L. Hill, M.D., Peru.**

What Malpractice Suits are Doing to You, the Patient

PERHAPS you, as an individual, have never considered suing a doctor for a real or fancied wrong, but unfortunately a great many other patients are doing just that—and winning fantastic sums of money, even when a doctor is really not to blame. The suit is usually judged by a jury of individuals who each have a favorite bone to pick with someone in the health field—as juror in someone else's suit claiming malpractice, each one gets a vicarious delight in hitting at all doctors through the decision against this one unfortunate man who happened to be somebody's legal target.

Yes, we know that some malpractice suits are justified, but let's be realistic and know that many of them are not! Therefore, in the long run, who is being hurt by these winning decisions in malpractice suits—not necessarily the doctor, because he is usually insured for this contingency. Not necessarily the patient who sued and won, because the money blinds him to his own greed and vindictiveness. No—but every other patient of that doctor and of all the doctors who are unjustly sued will be paying for the suit by one patient. Why? The doctor who loses a malpractice case loses not only a certain amount of prestige because of the bad publicity, he loses a favorable rating with the insurance company that paid the judgment. His malpractice insurance rate goes up a great deal, with the result that his fees must go up, too.

And, his confidence and trust in new patients is gone. Never again will he go wholeheartedly into a new case. He will be guarded and afraid to try anything new with a patient, unless that patient assures him in writing that he will be satisfied with whatever results are or are not obtained.

So who loses in a malpractice suit? The doctor loses only once, but the

patients who pay in the loss of a good doctor's trust, in higher prices for his services, and in finding out that more and more doctors are going into research, to get away from patients and their suits against them, --they are the ones who lose!

There are not enough good doctors around today. Before *you* turn a good doctor off, how about turning on to yourself and find out why you want to sue? Are you angry because the doctor isn't God? Are you angry because he is so busy that he can't give you the courtesies you expect of your grocer or doorman? Are you angry because he couldn't come to you, waiting in his office, because he had to stay with a patient in the hospital?

Yes—you're angry. You're angry about all the doctor/patient stories you've heard and you're hoping to get a piece of the malpractice action for yourself.

Please don't. You'll be losing a chance at living under the care of a good doctor, for a lot of others, for those who know that to have a doctor who trusts you and who trusts your faith in him, means a great deal more than money in a law suit.—**Jessyca Russell Gaver, editor,** *Living Health Newsletter,* **October 1, 1969. Reprinted with permission.**

Editorial Notes . . .

Zenith announces a classroom auditory trainer system especially suited for instruction of deaf children. It operates thru a fixed microphone which picks up conversational tones within a radius of 15 feet and then amplifies the output to a uniform level of sound. The system operates from a magnetic signal projected from a wire loop surrounding the classroom. The signal is received on the child's hearing aid. The teacher is freed from speaking into a hand-held or collar microphone with its trailing cable, and may utilize visual aids to the fullest extent.

Twelve-year-old Leonard Evans of Cincinnati furnishes blood plasma samples for diagnostic purposes to patients all over the world. His blood lacks Factor VII (convertin), a rare condition which exists in the congenital form in only 25 or 30 persons worldwide. It may be acquired, especially with liver disease, and the specific serum for its diagnosis is important. Leonard has contributed his plasma since the age of one. His unique status in this respect depends upon the fact that most of the other living members of his club are too old or too ill to donate the blood.

The state of Ohio is opening its fourth medical school, the Medical College of Ohio at Toledo. It is the nation's 100th medical school. The first class of 32 students entered last September. It will have academic relationship with Bowling Green State University and the University of Toledo, and clinical affiliations with five major hospitals.

Mead Johnson Laboratories is introducing a means of applying computer technology to assist in medical diagnosis. The system does not make a diagnosis. After a physician enters all his diagnostic findings, the computer responds with a list of conditions which are compatable with the findings. It also lists additional findings which may be useful for narrowing the diagnostic possibilities. The system will go under the name of Computer Assisted Diagnosis (CAD). The teletypewriter, which is used to feed information into the computer and receive its responses, may be in a doctor's office, in the hospital, or in a clinic.

Calcium elenolate, a drug obtained from extracts of olive plants, has been found by virologists of the Upjohn Company to inactivate a broad spectrum of viruses, including those responsible for herpes, influenza, the common cold, and polio. Viricidal action has been demonstrated in hamsters inoculated with parainfluenza type 3. The drug has been well tolerated by human volunteers, but full-scale human clinical trials are yet to be made.

Hospital planning is improving. The late Mies van der Rohe, one of the world's great architects, designed an extended care facility shortly before his death. His firm and the American Hospital Supply Corporation have made the work available for use. Especially planned for extended care or post-acute patients, it is designed to be connected with existing general hospital facilities and could save hospitals as much as 50% of the patient/day cost. The design incorporates both reduced construction and operational savings and is oriented toward diversional and occupational therapy to get the patient active again. The van der Rohe prototype is designed for rehabilitation and not a nursing home, the firm explained.◀



Lounge Talk

LLOYD L. HILL, M.D.
Peru

THE 120th Annual Convention of the ISMA was a well-attended, congenial session which considered many matters, most of which were not of any monumental importance, but which, nevertheless, will have an effect in a subtle fashion upon the practicing physician. Most of the actions taken by the House of Delegates update the modus operandi of ISMA seeking a broader and more functional scope of operation.

Perhaps it is more appropriate first to give you a candid appraisal of our top leadership which made its annual procession at the final meeting of the House of Delegates. I realize my opinions are only those of a small fish swimming in an ocean of big fish, nevertheless, by virtue of being from just this perspective, these opinions are less tainted with the bias of those dedicated physicians who precariously climb the ladder of political offices and hence must remain "politically expedient." (Nasty words!)

Immediate past-president Dr. Pat Corcoran of Evansville, Indiana, served his duties most efficiently in a pleasingly quiet, diplomatic manner. Dr. Corcoran is a true spokesman for the practicing physician. Organized medicine will do well in keeping this little Irish internist active in the main cogs of its intricate machinery. The House of Delegates wisely denied his "parole" by electing him to serve as alternate delegate to the AMA.

Our new president, Dr. Lowell Steen, another internist, but from the opposite end of the state, is a very dynamic, enthusiastic and, at times, brusk individual. These adjectives are intended kindly but sincerely because I do feel that with proper and timely restraint from the membership, this tall "bronco" can be saddled and broken to lead us well to newer dimensions vitally needed to contend with the unique problems we must now face in modern medicine. However, let the membership be warned that without their scrutiny and guidance, our leadership this next year can lead us headlong into oblivion with the president's multidirectional enthusiasm. Like so many other monstrosities already perpetrated upon the American public today that had their origins in the well-intended minds of dreamy-eyed politicians, many of his programs have the ambivalent potential of preserving the concepts of the private practice of medicine or wreaking havoc upon them, depending upon the guidance or lack thereof of the membership. No one can doubt Dr. Steen's sincerity, dedication and devotion to the causes of organized medicine, however.

The members of the House of Delegates had a difficult choice of men running to serve as president-elect in Dr. Malcolm O. Scamahorn, a GP from Pittsboro and Dr. Donald R. Taylor, a radiologist from Muncie. Both men are well qualified and are highly seasoned for this high office. "Dr. Malcolm" squeaked out a narrow victory. He is hereby notified, however, that a "little fish" with a verbose pen is watching him. I certainly wish him the best and am expecting great accomplishments from this large hulk of a man who has served us well for many years in diversified fields of organized medicine.

The deliberations of the final session of the House managed to run its usual marathon, lasting some four and one-half hours (no meals furnished either—please note dues-paying members!). It is indeed noteworthy to call to your attention that nearly half of the membership of ISMA was *NOT* represented in the roll call vote calling for a $10.00 increase in annual dues. This was simply because of the absence of nearly half of the delegates at the time the roll call vote was taken. True enough most of us were exhausted and anxious to get home, but this is a most vital and sensitive issue and deserves conscientious consideration and vote which is truly representative of the ISMA membership. However, the fault here lies in the laps of you members back home for not insisting upon your delegates representing your interests by remaining to vote on all vital issues. Furthermore the widespread absenteeism noted above is glaring proof of the value of having some means whereby you can hold your delegate accountable for his actions. In my book, not being present to vote is more derelict than a conscientiously considered but unfavorable vote.

Much of the work of the Future Planning Committee was geared in the direction of better serving the desires of the general membership and highly deserves the bouquets from this quarter. It has been my long-term observation and opinion that many of our previous leaders have sought policies that have filtered down from or which will receive the approval of higher echelons of organized medicine. While I do not question their motives or wisdom, I certainly feel that each representative should be the spokesman *for* rather than *to* those whom he represents. He should merely exchange ideas with those of other constituencies and utilize only those opinions which will benefit his own constituents—political popularity be damned. But you see, we little fish remain little because our delicate gastronomics develop hyperemesis when the big fish continue to pollute our ocean with that neatly masked poison known as "political expediency." ◄

302 N. Duke St.
Peru 46970

The Woman's Auxiliary

REPORTS TO ISMA

To the members of the House of Delegates of the Indiana State Medical Association, and all members of the ISMA, I want to say a very sincere "thank you" for the courtesies shown me as I represented your wives and gave a report of woman's auxiliary activities at your 120th annual convention. At the President's Reception and Dinner I wore the lovely orchid from all of you with pride, and felt most elegant.



It was our extreme pleasure to have Dr. Corcoran join the medical auxiliary for luncheon. Personally, it was a joy and privilege to be associated with Dr. Corcoran, and I look forward to working with your new president, Dr. Steen.

Our goal is to make the helping hands of the doctor's wife reflect and enrich the physician's dedicated service to mankind. As I visit county auxiliaries, I like to emphasize the auxiliary community service program, health careers and AMA-ERF.

In auxiliary we stress programs that give members that which they cannot get elsewhere. Our auxiliary projects demonstrate to the community that physicians' wives are people who care.

We measure our success by some of the following: when our medical society begins to talk about our auxiliary, and writes us to participate in society activities; when personal friends, community organizations, and the press begin to express an interest in what the auxiliary is doing; and when just one grateful person comes our way to say "thank you" for a needed helpful hand—we have been successful, and added a new dimension and a new word to our life—partner—a partner in caring about the problems of a muddled world—a partner in our husband's profession and his life's goals. When physicians' wives participate in the solution of a common problem, genuine improvements are realized, and when people understand, and are motivated, it becomes possible to move mountains.

Time has not dimmed the wisdom of Cicero, when he observed that "in nothing does man so nearly resemble the Gods, as he does when working for the well-being of his fellowman."

Sylvia Schneider





The editor and the staff of

The Journal wish you all

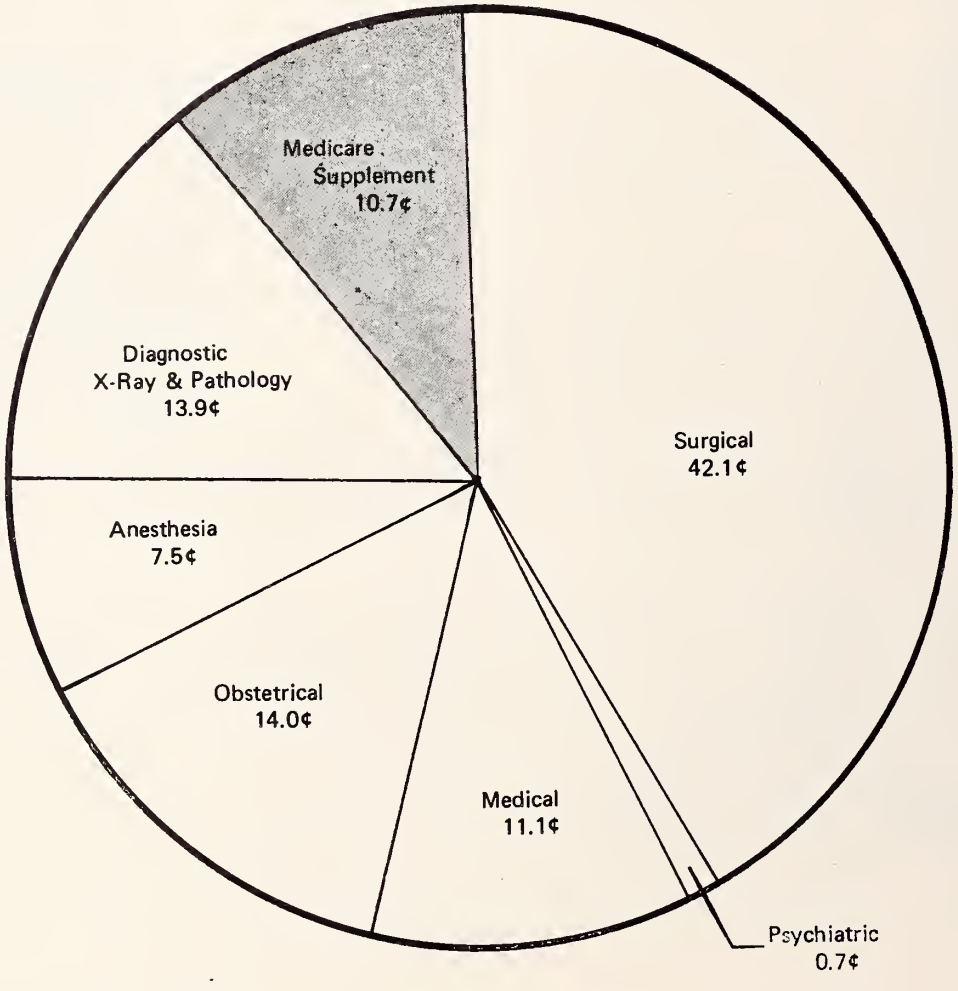
a Very Merry Christmas and

a Peaceful, Happy New Year

Merry Christmas

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(One of a series prepared by Indiana Blue Shield)



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Contraindications: Hypersensitivity to tetracyclines.
Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.
Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

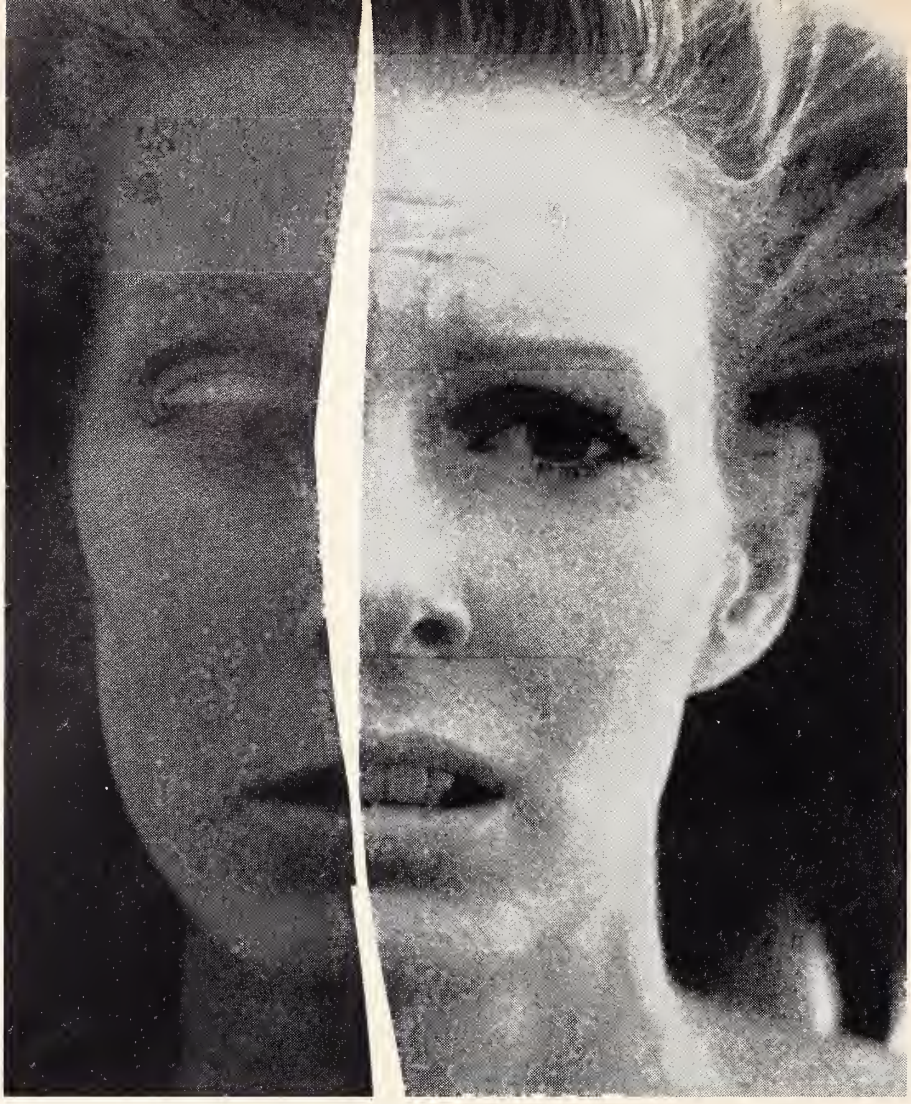
Side Effects: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

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symptoms of mixed anxiety-depression are rarely clear-cut.
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effective in mixed anxiety-depression and in moderate to severe anxiety

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Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

SANDOZ PHARMACEUTICALS, HANOVER, N.J. SANDOZ 69-384

South American Medical Tour

WEI-PING LOH, M.D.
Gary

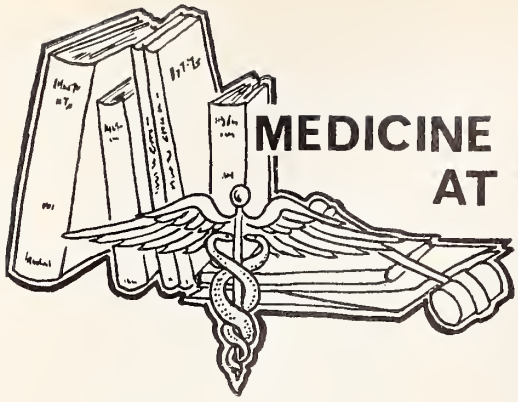
A South American Medical Tour was successfully sponsored and conducted by the Fort Wayne Medical Society for members of the Indiana State Medical Association February 19-March 5 under the chairmanship of Larry Pickering, Travel Committee, and W. P. Loh, M.D., Medical Seminar Committee. More than 100 physicians and their families participated in the tour which was one of the 11 South American Medical Tours involving 11 state medical societies. Dr. Loh served as medical program chairman for all 11 groups and traveled with the first group representing the Cincinnati Medi-Club. Each group traveled by a chartered jet and spent four days each in Ecuador, Argentina and Brazil. The guest speakers from each of the three countries were superb and their lectures were thoroughly enjoyed.

Medical Program

1. Medical education and medical care in Ecuador (Prof. Leonado Cornejo S., Dean, Universidad Central del Ecuador Facultad de Ciencias Medicas).
2. Use of hallucinogenic plants by primitive Indians (Prof. Plutarco Naranjo).
3. Local medical pediatric problems (Prof. Nicolas Espinosa Roman).
4. Visit to Hospital "San Juan de Dios."
5. Visit to Social Security Clinic and the new Social Security Hospital (750 beds).
6. Medical education and medical care in Argentina (Dean Santas, Prof. Mario M. Brea and Asst. Prof. Tomas Angelillo-Mackinlay, Universidad de Buenos Aires, Argentina).
7. Chagas' disease (Prof. Parodi and Dr. Alberto Cerisola).
8. Surgery for gastric and duodenal ulcers (Dr. A. G. Weyland, Chief Surgeon of Deutsches Hospital).
9. Lymphangiography (Dr. Antonio Di Rienzo).
10. Visit to new medical school hospital (or to Matera Clinic of Neurosurgery).
11. Visit to Di Rienzo Clinic (Institute of Radiology).
12. Medical education and medical care in Brazil (Dean Leme Lopes and Dr. Wilson Penna, Universidade Federal do Rio de Janeiro Faculdade de Medicina).
13. Syndrome of portal hypertension (Prof. Jose de Paula Lopes Pontes).
14. Schistosomiasis (Asst. Prof. Alfred Lemle or Dr. Berg).
15. Visits to Hospital Escola S. Francisco de Assig, I.N.P.S. Hospital of Lagoa and Colegio Brasileiro de Cirurgioes.
16. Surgical treatment of chronic pancreatitis (Dr. Augusto Paulino).
17. Percutaneous cholangiography (Asst. Prof. O. F. Gouveia).
18. Diagnosis of schistosomiasis (Asst. Prof. O. F. Gouveia).
19. Diverticulosis (Dr. D. G. Pereira).
20. Hemorrhagic fever (Prof. J. Rodrigues Coura).
21. Pediatric surgery (Dr. C. S. Leite).
22. Proctology in Brazil (Dr. Felipe Figliolini, Sao Paulo, Brazil).
23. Hemoglobin S (Assoc. Professor W. P. Loh, Chicago Medical School, U.S.A.) ◄



Dr. Loh (center) and Cincinnati physicians in Argentina.



Ordering Emergency Medical Care for Child—A court should order emergency medical procedures for a child over the parents' opposition only when the youngster may die, suffer agonizing pain, or become physically impaired without the treatment, according to the National Council on Crime and Delinquency.

This approach is advised in a pamphlet, *Guides to the Judge in Medical Orders Affecting Children*, issued by the Council. Copies of the pamphlet, at 35c a copy, may be ordered from the Council, located at 44 East 23 Street, New York, 10010.

Under the "doctrine of relative risk", the judge should weigh the hazards faced by the child if he is treated against the damage confronting him if he is not treated. The Council favors the general principle that the wishes of the parent should control where there is doubt about the effectiveness of a proposed medical procedure which poses great danger or risk of death to the youngster. However, where death or serious disability is imminent if the child is not treated, parental discretion must give way to medical efforts reasonably expected to aid the child.

The Council suggests that where there is a choice of medical procedures, the court should order the physician to take the course least objectionable to the parents, even if it involves more medical risk than another. For example, a medical procedure promising only a 40% chance of success but which the parents approve should be chosen over one promising an 80% chance but which the parents oppose.—News Release, National Council on Crime and Delinquency, New York, N.Y., Nov. 6, 1968.

"Discovery" Rule Applied in Foreign Object Case—Summary judgment was denied to a physician and a hospital in a patient's suit against them for leaving the blade of a surgical knife in her body during an operation for the removal of a stomach tumor. A previous ruling that the suit was barred by the three-year statute of limitations was reversed by the Washington Supreme Court. Reversal was made necessary by the court's recent adoption of the "discovery" doctrine in foreign object cases.

The operation was performed in October, 1954. This suit was filed in February, 1966. The patient alleged that she did not discover the blade's presence until October, 1965.

When the suit was commenced and throughout the subsequent proceedings, including the argument of this appeal before the supreme court, the rule in effect was that, in cases involving the leaving of foreign objects in a patient's body during surgery, the statute of limitations began to run at the time of the doing of the negligent act. After this appeal had been argued, the court, in *Ruth v. Dight*, 453 P.2d 631 (*The Citation*, Vol. 19, No. 8, p. 118), rejected that rule. In its place, the court adopted the rule that, in foreign object cases, the statute begins to run when the patient discovers or, in the exercise of reasonable diligence, should have discovered the presence of the foreign object in his body.—*Denison v. Goforth*, 454 P.2d 218 (Wash., May 1, 1969).

"Locality" Rule Followed—An anesthesiologist's testimony was properly excluded in a suit against an obstetrician for injuries caused by his allegedly negligent administration of saddle block anesthesia, a federal appellate court ruled. The anesthesia was administered in Colorado Springs, Colorado, and there was no showing that the anesthesiologist, who was from Seattle, Washington, was familiar with the standards of practice in Colorado Springs.

The obstetrician had taken the anesthesiologist's deposition but did not put it into evidence. The patient sought to put portions of the deposition into evidence to prove the standard of care required of the obstetrician and to support her theory of liability under the doctrine of *res ipsa loquitur*. The trial court refused to admit the evidence because no showing was made that the anesthesiologist was familiar with the standards of practice in Colorado Springs or similar communities and because there were significant differences between the specialties of obstetrics and anesthesiology.

The law of Colorado governed. Colorado follows the "locality" rule —that a physician's conduct is to be measured against the standards of practice of physicians in the same or similar communities.

The anesthesiologist has written books on the science and practice of anesthesiology, with special emphasis on spinal block techniques. Those books are standard texts in medical schools. He testified that, although the standard practices might vary from community to community, the

general principles of administering a saddle block are fairly well established and generally adhered to. The obstetrician testified that he recognized the anesthesiologist as one of many authorities in the field, but that he did not follow his technique. The trial court could properly find, from this evidence, that the patient had failed to establish that the anesthesiologist was familiar with the standards of practice in Colorado Springs or similar communities. Further, the patient failed to show that the standards for administering spinal anesthesia would be the same for an obstetrician as for an anesthesiologist.

The trial court did not err in refusing to instruct on the doctrine of *res ipsa loquitur*. There was no evidence of a prescribed standard of care the observance of which would have avoided the injury.—*Murphy v. Dyer*, 409 F.2d 747 (C.A. 10, March 10, 1969; rehearing denied, May 29, 1969).

Student Successful in Suit for Commitment—A university student who had been committed to a hospital mental ward on the basis of a commitment form signed by university officials was awarded damages totaling $47,001 by a Wisconsin trial court jury in her suit for false imprisonment against the university and the officials.

The student was 16 years old at the time of the incident. She had threatened to drop out of school without parental consent and run away. The school officials who signed the special commitment form testified that they did so because they thought she was mentally ill and because their numerous attempts to reach her parents had been unsuccessful.

The university was ordered to pay $35,000 in punitive damages and $5,000 in compensatory damages. The officials who signed the commitment form, the dean of women, a physician, and a nurse were ordered to pay, respectively, punitive damages of $5,000, $2,000, and $1.—News Release, Milwaukee, Wisconsin, Aug. 9, 1969.

Viable Fetus Held to be "Person"—A driver was convicted by an Ohio trial court of vehicular homicide for having caused the death of a seven-month, viable, unborn child while driving under the influence of intoxicating liquor. The child was a "person" within the meaning of the vehicular homicide statute.

The child was born dead about 36 hours after a collision between the driver's car and one in which her mother was a passenger. An autopsy disclosed that the cause of the child's death was hypoxia, due to placental hemorrhage which was the result of uterine contusion suffered by her mother in the collision.

The physician who performed the autopsy testified that the fetus was seven months old and was capable of sustaining life outside her mother's body.

The vehicular homicide statute clearly limits the crime to the death of a "person." "Person" must be taken to mean a living individual. The medical evidence established that the child was living at the time of the accident and was strangled to death as a result of the accident. Such a child was clearly within the contemplation of the statute.—*State of Ohio v. Dickinson*, 248 N.E.2d 458 (Ohio, June 4, 1969).

Hospital Liable for Fall from Bed Without Siderails—A hospital was held liable for injuries sustained when a patient fell from a bed on which no siderails had been attached, contrary to the teachings in the manual for the guidance of the nurses in the hospital. The ruling was made by the Supreme Court of Ohio.

When the patient entered the hospital, she was placed in a bed which had rollers and raised siderails on it. Later she was transferred to a bed which had rollers but no siderails, and it was from this bed she fell. The evidence showed that she had been given drugs during the four days prior to the time she fell from her bed and that she was in a sedated, foggy, and disoriented state. On the day before she fell, she was allowed to get up once to go to the bathroom, but because she was so short of stature and obese, she was provided with a footstool to help her get from and to her bed. She was also assisted by a nurse's aide. The patient's doctor testified that he had not ordered siderails because he wanted the patient to be up and around. However, he had not specifically directed that the siderails be removed.

The hospital administrator testified that the teaching manual of the hospital's school of nursing prescribed a standard of care which the nurses who graduate therefrom are to follow in the care of patients in the hospital. This manual provided that siderails should always be applied to the bed of a patient who is restless, very obese, or under deep sedation, or in any other case where siderails would be an added protection. In fact, it stated that in any case when the patient's condition warranted siderails, they were not to be omitted except upon the written order of the attending physician. The manual also provided that if the patient is permitted to get up alone, or if he is likely to get up without permission, the rollers on the bed must be removed, rather than siderails applied.

Under the circumstances presented by the evidence, the court held that it was a jury question as to whether the hospital was negligent in not applying raised siderails to the patient's bed. The jury had to determine whether the hospital exercised reasonable care in promulgating and enforcing rules to protect the patient against the dangers incident to the patient's condition. The court held that the jury was justified, on the evidence, in finding in favor of the patient and against the hospital. —*Burks v. The Christ Hospital*, 249 N.E.2d 829 (Ohio, July 9, 1969). ◄



ABSTRACTS, BOOK REVIEWS

GIVE ME LIFE
The Heart Transplant—"If" and "When"

William J. Pierce, DorNic Publishers, Bruceville, Ind., 1968; 120 pages; $4.98.

This is preventive medicine. It is written by a pathologist in laymen's language to explain the nature and prevention of coronary heart disease.

An explanation in common terms of the tissue changes in heart disease establishes a basis for a full discussion of typical clinical cases as seen by the autopsy surgeon. Physiology and metabolism are discussed enough to instruct the patient in his understanding of preventive measures which are applicable during his entire lifetime.

Diet, exercise, weight control, and living habits are covered meticulously, and with enough vigor to stimulate patient compliance.

Patients should read this book to further their own understanding of a common disease and as a basis for further discussions with their doctors.

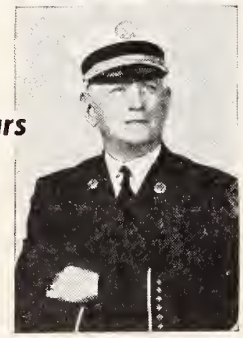
FRANK B. RAMSEY, M.D., Editor
Indianapolis

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PHYSICAL DIAGNOSIS—
The History and Examination of the Patient

John A. Prior, M.D., Jack S. Silberstein, M.D., The C.V. Mosby Company, St. Louis, Mo., third edition, 1969; many figures; 436 pages; $10.50.

This new third edition shows further improvement over the previous editions. A new chapter on examination of the skin has been added; a relatively detailed review of body systems has been included. Considerable space is devoted to the development of the patient's history. In physical examination the new added areas include evaluation of hearing, measurement of visual fields, localization of blind spots and bedside tests for venous competency in the extremities. Many areas have been revised for better understanding. Totally there are 17 chapters written by 12 contributors, mainly from Ohio State University. The paper and printing are both of superior quality. The price is quite reasonable.

The weak areas are very few and are not significant enough to be mentioned. In general, the book is to be highly recommended for both medical students and practicing physicians.

WEI-PING LOH, M.D.
Gary

GENETICS AND COUNSELING IN MEDICAL PRACTICE

Leonard E. Reisman and Adam P. Matheny, Jr., The C. V. Mosby Co., St. Louis, 1969; 215 pages; 86 illustrations; $12.75.

Applied medical genetics is becoming an everyday component of the practice of the family physician. The average family physician, however, does not have the time to follow all of the developments in the field. Not infrequently, the questions asked by patients or their families require answers not immediately available. There have been a number of new texts and reference volumes recently published on the subject of medical genetics in response to the need for collecting these facts in a single volume. *Genetics and Counseling in Medical Practice* is a useful and readable new book with an emphasis on practical clinical information and genetic counseling.

The general subject of genetics has recently been given widespread exposure in lay publications, so such information reaches the patients and their families almost at the same time that the physician becomes aware of it. The partially informed patients in such situations may baffle the family physician with relatively technical questions. In such situations, incorrect information may be provided by the well-meaning physician as pointed out by genetics counselors of the stature of Sheldon Reed, Ph.D, Dight Institute of Human Genetics, University of Minnesota. Serious social damage can result from incorrect counseling of this nature. This text provides a valuable source of accurate information useful in avoiding such unfortunate situations.

Genetic counseling, which appears to be a speciality in itself, involves the primary physician in the diagnosis of the entity. It is he also who is frequently asked for family planning advice. An entire section of this valuable text is devoted to the presentation of methods of communicating information on this relatively complex subject.

The text is readable, and contains numerous useful clinical examples. The many pictures and chromosome studies are well designed and informative. The book provides a brief discussion of available methods of obtaining medical history, and specific points of interest in physical examination. Brief discussions of the available laboratory technics are given, including sex chromatin and chromosome analysis. Discussions on subjects of research interest are avoided. Entire chapters are devoted to the subjects of

genes, birth defects and statistical probability in genetie counseling which have particular interest for the family physician. The main portion of the text is devoted to practical information about the more frequently encountered hereditary syndromes. For those with a special interest in genetics this volume is an outline serving as a brief review on specific topics.

Each chapter is followed by a short list of appropriate references, although few 1968 references are included. A valuable list of the available service facilities for genetic counseling in this country is presented in the chapter on "Future Perspectives in Genetic Counseling." One omission which undoubtedly will be corrected in subsequent editions is a glossary of genetic terms. A list of the hereditary patterns and genetic risk of the numerous syndromes would also be helpful. The recent genetic literature includes a large number of articles concerning mosaicism, particularly XO/XX and YY/XYY, but this subject is only covered superficially.

The index is comprehensive, with the inclusion of relative obscurities such as Burton's disease, Holt-Oram syndrome, as well as the more common clinical syndromes.

JAY S. FLEISHMAN, M.D.
Muncie

Abstracts From Various Literature, Prepared by AMA

EFFECTS OF DIAMORPHINE, METHADONE, MORPHINE, AND PENTAZOCINE IN PATIENTS WITH SUSPECTED ACUTE MYOCARDIAL INFARCTION

M. E. Scott and R. Orr (Royal Victoria Hospital, Belfast, Ireland)

Lancet 1:1065-1067, (May 31), 1969.

A double-blind between-patient comparison of the effects of 5 mg of intravenous diamorphine (heroin), 10 mg of methadone, 10 mg of morphine, and 30 mg of pentazocine was performed on 118 patients with pain due to suspected acute myocardial infarction. Ten minutes after injection, diamorphine gave complete relief from pain in a significantly greater percentage of patients that morphine or pentazocine, though not in a significantly greater percentage than methadone. Otherwise the analgesic effect of the four drugs was similar. Pentazocine often produced a rise in systolie blood pressure, particularly when this was low before administration of the drug. Pentazocine is possibly preferable to the narcotic drugs for the relief of the pain of acute myocardial infarction.

NONMEDICAL PERSONNEL AND CONTINUOUS ECG MONITORING

C. L. Foster, G. C. Casten and T. J. Reeves (University of Alabama Medical Center, Birmingham)

Arch. Intern. Med. 124:110-112, (July), 1969.

A continuous ECG monitoring system outside of a coronary care unit is described whieh uses specially trained college-age men as monitoring technicians. There have been 288 patients monitored during the first 18 months of operation. The identification and successful treatment of 41 episodes of cardiac arrest in eight patients who did not have acute myocardial infarction points up the value of monitoring patients with heart block, coronary disease without infarction, and following elective cardioversion. These patients would not ordinarily have been admitted to a special care area. The availability of personnel and the economic feasibility of this type of continuous ECG monitoring permit a much wider image.

CLINICAL EVALUATION OF DIURETICS IN CONGESTIVE HEART FAILURE

R. N. Mahabir (Harvard Medical School, Boston) and S. T. Laufer

Arch. Intern. Med. 124:1-7, (July), 1969.

Five balance studies were performed in four patients with congestive heart failure to elucidate the role of diuretics in the genesis of electrolyte disorders and cardiac arrhythmias. In comparable doses, hydrochlorothiazide produced greater negative potassium and chloride balances than furosemide. When these agents were combined with triamterene the potassium and chloride losses were significantly minimized and sodium loss accentuated. With the dosage used in this study severe cardiac arrhythmias were often precipitated by hydrochlorothiazide, but rarely by furosemide. Triamterene restores potassium loss and brings about a disappearance of the arrhythmias. Potassium metabolism plays a dominant role in the pathogenesis of these arrhythmias.

SQUAMOUS CELL CARCINOMA ARISING IN HIDRADENITIS SUPPURATIVUM

L. J. Humphrey, H. Playforth, and U. W. Leavell (University of Kentucky Medical School, Lexington)

Arch. Derm. 100:59-62, (July), 1969.

A 48-year-old white man noted onset of his perianal disease eight years before squamous cell carcinoma was diagnosed. Eight months

Continued



before definitive surgery, the patient noted a change in the disease. Over the next four months, this cauliflower lesion was cauterized and treated as a fungus infection. Previous cases from literature are compared with this one, especially regarding the time interval between onset of hidradenitis and the complicating carcinoma.

AUTOTRANSFUSION DURING TRANSURETHRAL RESECTION OF PROSTATE

J. D. Wilson (Mayo Graduate School of Medicine, Rochester, Minn.), D. C. Utz, and H. F. Taswell

Mayo Clin. Proc. 44:374-386, (June), 1969.

In 11 cases of transurethral resection the cellular components of the blood lost were extracted from 20 to 40 liters of blood-irrigating fluid mixture, washed, and resuspended to a 20% to 40% hematocrit value before autotransfusion. The 11 autotransfused patients received 94% of the erythrocytes, 63% of the leukocytes, and 54% of the platelets lost during the resection. The patients tolerated the procedure well, with no gross evidence of hemolysis of the transfused blood cells. The decrease in postoperative hemoglobin, hematocrit values, and erythrocyte counts rapidly returned to normal when postoperative bleeding was minimal.

EXTRACORPOREAL IRRADIATION IN TREATMENT OF ACUTE LEUKEMIA

R. S. Souhami et al. (T. A. J. Prankerd, University College Hospital, Gower St., London)

Lancet 2:13-17, (July 5), 1969.

Extracorporeal irradiation of the blood (ECI) has been used in the treatment of five patients with acute leukemia. A high dosage was administered over a short period of time. The main effect of ECI was to produce a short-lived reduction in the numbers of circulating blast cells. Temporary clinical improvement was seen in one patient. Chemotherapy after ECI did not seem to be more effective than when given beforehand.



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LONG-TERM ANTICOAGULANT PROPHYLAXIS AFTER MYOCARDIAL INFARCTION

A. J. Seaman et al. (University of Oregon Medical School, Portland)

New Eng. J. Med. 281:115-118, (July 17), 1969.

In a double-blind randomized test, long-term prophylactic anticoagulant therapy after acute myocardial infarction did not reduce mortality rate nor complications. More treated patients required hospitalization than did patients not receiving anticoagulant drugs. Patients continuously entered the study between 1956 and 1967. The average period at risk was about six years. All patients received six weeks of anticoagulant therapy for initial and, time and circumstances permitting, for recurrent myocardial infarctions.

RECTAL EXAMINATION IN PATIENTS WITH ACUTE MYOCARDIAL INFARCTION

D. L. Earnest and G. F. Fletcher (Georgia Baptist Hospital, Atlanta)

New Eng. J. Med. 281:238-240, (July 31), 1969.

Rectal examination is commonly deferred or omitted in patients with acute myocardial infarction. To evaluate the safety and specific usefulness in this clinical setting of an otherwise routine procedure, a gentle digital rectal examination was performed in 86 patients with acute myocardial infarction within 24 hours after their hospitalization. No adverse clinical or electrocardiographic effects were observed and no angina pectoris was produced. The unsuspected presence of fecal occult blood, prostatic enlargement, and voluminous hard stool was encountered frequently enough to make rectal examination a useful adjunct in planning care for this patient group.

SYSTOLIC MURMURS INDUCED BY PACEMAKER CATHETERS

G. H. Nachnani, A. S. Gooch, and I. Hsu (George Washington University Hospital, Washington, D.C.)

Arch. Intern. Med. 124:202-205, (Aug.), 1969.

Superficial, scratchy systolic murmurs with middle and late systolic clicks developed in three patients soon after the placement of transvenous catheter pacemakers in the right ventricle. Two patients had arrhythmias associated with myocardial infarction and one had long-standing Stokes-Adams attacks. The murmurs and clicks varied in intensity with body positions and the intensity increased with inspiration. None of the patients developed jugular vein V waves or clinical evidence of heart failure. Simultaneous phonocardiograms, intracavitary ECG, surface ECG, and videotape recordings, made during withdrawal of the catheter, demonstrated disappearance of the murmur and clicks with entry of the tip into the right atrium. The presence of hemodynamically insignificant tricuspid regurgitation is supported by the location of the murmurs (lower left sternal border), their augmentation with inspiration, and disappearance with removal of the catheter. ◄

From *The Journal* 50 Years Ago

"American babies are better fed than any others in the world," says the *Modern Hospital,* Chicago, in discussing the question of child feeding. It says further that although there are still people who feed their babies coffee and pickles, the modern trend toward proper diet for babies and children is being distinctly shown today. The modern way makes good babies not only because their food needs are better understood and more skillfully met, but because emphasis has also been placed on regular meals, proper sleep, plenty of fresh air and freedom from fatigue or excitement.

The diet of the normal baby should include plenty of milk, green vegetable juices or pulp (all properly strained) and orange juice. Growing children should have regular meals, an adequate number of meals with food well distributed among them, bland and easily digested foods such as milk, cereals, breads and potatoes; simply prepared foods free from high seasoning. Along with this food selection there must be plenty of sleep, freedom from overwork or excitement and intelligent education in eating habits.

Given time enough, and excluding food actually harmful to the individual, one can teach any child to eat anything. We need better food education for mothers and more food education of children in school. . . . Editorial Notes, *JISMA,* December, 1919.

★

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MONTHLY REPORT—October, 1969

Disease	Oct. 1969	Sept. 1969	Aug. 1969	Oct. 1968	Oct. 1967
Animal Bites	890	913	1221	687	760
Chickenpox	191	31	41	130	91
Conjunctivitis	86	74	122	54	42
Diphtheria	0	0	0	0	1
Dysentery, Unspecified	4	5	21	23	33
Gonorrhea	739	656	685	497	398
Impetigo	285	176	189	183	204
Infectious Hepatitis	70	46	21	33	63
Infectious Mononucleosis	89	36	20	82	53
Influenza	870	588	272	890	777
Measles					
Rubeola	3	1	1	15	24
Rubella	75	26	38	64	21
Meningitis, Meningococcal	6	1	2	1	1
Meningitis, Other	7	3	4	1	3
Mumps	127	56	93	105	65
Pertussis (whooping cough)	7	8	3	13	24
Pneumonia	230	139	137	189	153
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	564	333	328	368	446
Syphilis					
Primary & Secondary	38	39	27	32	29
All Other Syphilis	97	85	81	117	51
Tinea Capitis	16	3	6	9	2
Tuberculosis (active)	70	62	82	80	65

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Each tablet and each 5 cc. of liquid contain:
diphenoxylate hydrochloride . . . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate, 0.025 mg. (1/2,400 grain)

body fluids...
electrolytes...
patients from exhaustion

Lomotil acts promptly and directly to lower the excessive intestinal motility of diarrhea. This therapeutic restraint on the overactive bowel allows a normal or more nearly normal reabsorption of water and electrolytes.

The proficiency of Lomotil in conserving body fluids and electrolytes often saves patients from the exhaustion that accompanies prolonged diarrhea.

Lomotil acts to control the intestinal mechanisms of diarrhea; therefore, it is highly useful in controlling diarrhea associated with:

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irritable bowel · ileostomy · drug-induced diarrhea

Warnings Lomotil should be used with caution in patients taking barbiturates and with caution, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a Federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur, signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary. The subtherapeutic amount of atropine sulfate is added to discourage deliberate overdosage.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise. Respiratory depression and coma may occur with overdosage.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

Children:	*Total Daily Dosage*
3-6 mo.	½ tsp.* t.i.d. (3 mg.)
6-12 mo	½ tsp. q.i.d. (4 mg.)
1-2 yr	½ tsp. 5 times daily (5 mg.)
2-5 yr	1 tsp. t.i.d. (6 mg.)
5-8 yr	1 tsp. q.i.d. (8 mg.)
8-12 yr	1 tsp. 5 times daily (10 mg.)
Adults:	2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

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ELASE Ointment is applied to a deep ulceration of a finger.

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to aid in debridement
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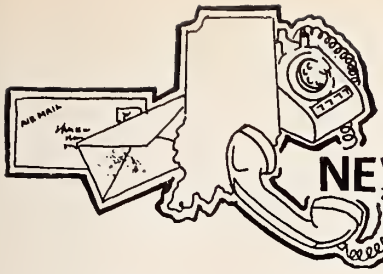
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By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation...*for healing*. Its lytic enzymes effectively break down DNA in dead leukocytes and other debris...the fibrin in blood clots, serum, and purulent exudates...and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. *Precautions:* Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. *Adverse Reactions:* Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. *Discussion:* Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. *Available:* ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg. thimerosal (mercury derivative); and in 10-Gm. tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg. thimerosal. ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package.

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PARKE-DAVIS

48168



NEWS NOTES

Indiana Medical Education Foundation Grants $100,000 to I.U.

Hoosier physicians are sensitive to the needs of their medical school. A check for $100,000 was presented to the I.U. School of Medicine at the annual banquet of the Indiana State Medical Association at the Murat Temple in Indianapolis in October.

The money, a grant from the Indiana Medical Education Foundation, represents gifts made by physicians to the American Medical Education Foundation and earmarked for the support of the Indiana medical school. Gifts are also received locally by the Hoosier foundation. The national foundation was organized by the American Medical Association and the Indiana foundation is sponsored by the Indiana State Medical Association. Gifts are made to both foundations primarily by physicians.

The Indiana Medical Education Foundation was formed in 1953 with a trust committee made up of six members elected by the Board of Trustees of the Indiana State Medical Association and six members from the faculty and staff of the school of medicine appointed by the president of Indiana University. Chairman of the committee this year is Dr. Roy Geider, Indianapolis anesthesiologist. The check for $100,000, the largest grant made by the foundation, was presented by the vice-chairman, Dr. Loren Martin of Indianapolis, to Dr. Glenn W. Irwin Jr., dean of the medical school.

In presenting the check, Dr. Martin pointed out that the foundation to date has made grants totalling $701,176.96 to the I.U. School of Medicine. This money has been made available to the medical school, he emphasized, with the understanding that it would be in addition to any regular budget established by the state and the I.U. Board of Trustees. The money is a measure, he said, of the physicians' concern that the school be able to maintain the highest quality of medical education.

"Grants such as this give the school of medicine the ability to help meet today's needs during a period of fiscal limitation," Dean Irwin declared in accepting the check. "It is through this kind of support that we have been able to maintain and increase the quality of the educational experience at our school. For instance, the money this year will be used to reinforce funding of new programs being inaugurated by new chairmen in three of the major departments. Some will be used for partial salary support for new faculty members in these departments and some will be used to further the programs in other ways. A portion of the funds will be used to renovate and update the medical student lounge area in the Medical Science Building.

"It is fitting," the dean continued, "that this largest grant made to date by the medical foundation should be used for these new and exciting programs as we move into our new University Hospital. It also is fitting that all this should be a part of the sesquicentennial celebration being held this school year by Indiana University."

Dr. Patrick J.V. Corcoran, Evansville, president of the state medical association, pointed out that the $100,000 grant was more than the $97,000 requested by the school of medicine. The other $3,000, he said, will be used by the Dean's Office for visiting professors and special lectures.

Capt. Acher Memorial Medical Library Planned at Greensburg

Friends of Dr. Robert P. Acher and his family of Greensburg, and friends of the Decatur County Memorial Hospital are establishing a medical library for the hospital in memory of Capt. Robert P. Acher II who lost his life in Vietnam on September 2 while serving with the United States Air Force. Contributions and messages may be sent to Bernard C. Harvey, Administrator of the hospital.

Dr. Brown Speaks

Dr. Robert R. Brown, Terre Haute, spoke recently at a workshop for nursing home personnel on the management of the cancer patient. Dr. Brown is chairman of the American Cancer Society's Professional Education Committee, Vigo County Unit.

Optimist Speaker

Dr. Thomas Keough, Warsaw, spoke on the topic of kidney and heart transplants at a recent meeting of the Warsaw Optimist Club.

Tuberculosis Speaker

Dr. J. Frank W. Stewart, Vincennes, addressed the annual joint meeting of the Sullivan and Greene County Tuberculosis Associations recently in Sullivan. He spoke on "New Approach of Eradicating Tuberculosis."

Continued



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Using brief and simple explanations, Dr. James Rogers Fox answers many of the medical questions so important in our day-to-day living.

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Listing of Sources of Short-Term Training for Laboratory Workers

The Laboratory Consultation and Development Section of the National Communicable Disease Center is compiling a list of organizations which offer short-term training for persons working in clinical and public health laboratories. Academic training for full-time students will not be included. When completed, the list will be made available to all individuals interested in continuing education for medical laboratory personnel. The compilation will serve to alert training coordinators, supervisors and prospective students to the existence of many little-known sources of short-term training, some at no cost to the student.

Companies, professional associations, individuals, and schools who desire to furnish information for inclusion in the listing should write: National Communicable Disease Center, Attention: Mr. John H. Krickel, Education Specialist, Laboratory Division, Atlanta, Georgia 30333.

No information will be included in the published list without prior clearance from the organization or individual offering the training.

Lions Speaker

Dr. Floyd M. Rheinheimer, Milford, appeared before the Milford Lions Club recently and showed a film, "The Red River of Life," a story of the human heart, and answered questions concerning the heart and circulatory system.

Positions available July 1, 1970 in fully approved Psychiatric Residency, also in Child Psychiatry; affiliated with university and mental health clinics in communities. Excellent supervision offered in a broad program with controlled number of patients in therapy. Also extensive training programs in other disciplines in same hospital, about fifty miles from downtown Los Angeles and about three miles from ocean beaches. Applicants who are foreign medical school graduates must have unrestricted license to practice in California. All others must be eligible for examination for California Licensure. **Write: Norman C. Mace, M.D.,** Camarillo State Hospital, Camarillo, California 93010.

Dr. Ruschli Honored

Dr. E. B. Ruschli, Lafayette, observed one of several celebrations recently when St. Elizabeth Hospital held a surprise party for him in honor of his 85th birthday. Dr. Ruschli marked the anniversary of his start in the practice of medicine earlier this year. He has been a physician and surgeon for 60 years; was the first physician to deliver a child at the hospital and was the first surgeon to practice in the first new wing at St. Elizabeth. Dr. Ruschli also has been chief of the surgical staff of the hospital at three different times.

Dr. Wilson Speaks

Dr. Norman J. Wilson, superintendent of Parramore Tuberculosis Hospital at Crown Point, discussed new concepts in patient treatment during the recent annual meeting of the Vigo County Tuberculosis Association.

"Parent-Teen-Ager Communication" Pamphlet Now Available to Physicians

"Parent—Teen-Ager Communication: Bridging the Generation Gap" is a Public Affairs Pamphlet by Millard J. Bienvenu, Sr. Dr. Bienvenu is head of the department of sociology of Northwestern State College of Louisiana and has written extensively.

The pamphlet is available from Public Affairs Committee, 381 Park Avenue South, New York City 10016, for 25 cents per copy.

Dr. Bard Named

Dr. Frank B. Bard, Crothersville, has been named president of the Alumni Association of the I.U. School of Medicine. **Dr. John Ling, Richmond,** was named president-elect; **Dr. Ronald G. Kleopfer, Fort Wayne,** vice-president; **Dr. Olga Bonke-Booher, Indianapolis,** re-elected secretary; **Dr. Lester D. Bibler, Indianapolis,** treasurer; **Dr. J. L. Arbogast, Indianapolis,** re-elected historian and **Dr. Dennis S. Megenhardt, Indianapolis,** named representative to the executive council of the general alumni association of I.U.

Named to Health Board

Dr. James Hedrick, Gary physician, has been appointed to the Gary Health Board to fill the unexpired term of **Dr. John Kolettis,** who resigned.

Dr. Beaver Named

Dr. Norman E. Beaver, Berne, has been named to a four-year-term on the South Adams School Board of that city.

PMA to Start Traineeships for Students in Clinical Pharmacology

A program to support the training of medical students in clinical pharmacology was originated by the Pharmaceutical Manufacturers Association Foundation three years ago and will be continued next year.

Twenty traineeships, each worth $1,000, will be awarded for the year beginning June 1, 1970. Special training in a research and training program will be pursued by each trainee for a total period of three months.

Dr. Silvero Speaks

The Fort Wayne Industrial Nurses Association heard a talk on "The Revolutionary Changes in Medicine" recently at their annual meeting and banquet. **Dr. Hubert L. Silvero, Churubusco,** was the speaker.



Dr. Gerald Dorman, president of the AMA, chats at the head table wtih Mrs. Patrick J. V. Corcoran and Dr. Lowell H. Steen.

Conference on Relationships With Voluntary Health Agencies

Representatives from 11 states met Saturday and Sunday, October 11 and 12 in Indianapolis, for an American Medical Association and an Indiana State Medical Association sponsored conference on relationships with voluntary health agencies.

Major emphasis in the two day program was placed on ISMA's current recognition program of statewide voluntary health agencies. The AMA's efforts with national groups and the Federal government in encouraging and developing broader voluntary efforts in health related fields also was stressed.

Dr. Norman R. Booher, Indianapolis, chairman of ISMA's Commission on Voluntary Health Agencies and also a member of the AMA Council on Voluntary Health Agencies, coordinated the meeting which attracted 120 individuals active in medical organization and voluntary agency affairs throughout the Midwest.

Miss Jayne Shover, Chicago, associate director of the National Easter Seal Society for Crippled Children and Adults, and consultant to President Nixon's national program for voluntary action, spoke at the Sunday noon luncheon.

Dr. Gerald Dorman, New York, president of the AMA, addressed the group at 9:00 a.m. Sunday.

Other speakers on the program included Dr. Norman S. Moore, Ithaca, N.Y., chairman of the AMA's Council on Voluntary Health Agencies, and Dr. Lewis January, Iowa City, Iowa, past president, American Heart Association.

Participants from the ISMA commission on the program besides Dr. Booher included Doctors Richard Willard, Bluffton; Albert S. Ritz, Evansville; and the new president-elect of the association, Malcolm O. Scamahorn.

Also on hand to greet the group were Dr. Lowell H. Steen, president, ISMA; Dr. Patrick J. V. Corcoran, immediate past president, and several members of the ISMA Board of Trustees.

Continued

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NEWS NOTES

Continued

Elected President

Dr. Richard N. Matzen, Bluffton, has been elected president of the Wells County Tuberculosis Association.

Physician Speakers

Dr. Marvin F. Greiber, Muncie, and **Dr. Hanns Grosz, Indianapolis,** spoke on a panel recently sponsored by the Delaware County Mental Health Association in Muncie.

Dr. Moore Speaks

Dr. Donald F. Moore, superintendent of LaRue Carter Memorial Hospital, Indianapolis, was the featured speaker at a luncheon meeting of the Mental Health Association in Henry County recently at New Castle. His topic was "Changing Concepts in the Nature of Delivery of Medical Psychiatric Treatment."

Dr. Bannon Named

Dr. William G. Bannon, Terre Haute, has been named chairman of the western Indiana area's 150th birthday fund campaign for Indiana University. Dr. Bannon will be responsible for coordinating the campaign in Putnam, Vigo, Parke, Sullivan and Vermillion counties.

Dr. Lett is Speaker

Dr. James C. Lett, Greencastle, addressed Greencastle High School pupils recently in a lecture series sponsored by the high school chemistry department. He urged the pupils to consider careers in medicine.

March of Dimes Speaker

Dr. Harold M. Trusler, Indianapolis plastic surgeon, was the principal speaker at the annual March of Dimes banquet held recently at Anderson.

Upjohn Medical Films Win Columbus Awards

Two films from the Upjohn Vanguard of Medicine(R) film series recently received awards at the Columbus, Ohio Film Festival.

"Lillehei on Stagnant Shock" was awarded the highest recognition in its category. "Cold-light Endoscopy" received a Certificate Award. Both films had previously received recognition by American and foreign critics. These and other films of the Upjohn series are obtainable on a free-loan basis.

Dr. Pearson on Panel

Dr. John S. Pearson, Indianapolis, participated in a panel discussion on Medical Management and Procedures during the 78th annual meeting of The Association of Life Insurance Medical Directors of America at Quebec City, Canada, on October 15.

Physician Promoted

Dr. William E. Stavropoulos has been promoted to the head of The Dow Chemical Company's Diagnostic Products Technical Service and Development Laboratory.

Dr. Montgomery Named

Dr. Lall Montgomery, Muncie, has been appointed to represent the Federation of State Medical Boards of the United States on the Advisory Board of Medical Specialties. **Dr. P. T. Lamey, Anderson,** is president of the federation.

Dr. Doherty Speaks

Dr. Raymond Doherty, Merrillville, was guest speaker at a recent meeting of the Independence Hill TOPS (Take Off Pounds Sensibly) Club at Hammond.

Elected President

Dr. Joseph Greenlee, Avilla, Noble County Coroner, has been elected president of the Indiana Coroners Association.

Dr. Bowen Honored

Dr. Otis R. Bowen, Bremen, has been presented a plaque from the Bremen Kiwanis Club in appreciation for his "unselfish service to Bremen and the state of Indiana and his commendable service in the State Legislature in the interest of all Hoosiers." Dr. Bowen was also presented with a pair of candlesticks made by the Indiana Brass Company at Frankfort when he spoke before the Frankfort Kiwanis Club recently.

Legal Pitfalls Facing Medical Assistants Shown in New Wyeth Film

An instructional film "Case In Point" has been produced jointly by the American Association of Medical Assistants and Wyeth Laboratories.

It stresses and explains precautions necessary for the medical assistant to avoid incidents involving legal liability. It is 16-mm, color and sound and runs for 25 minutes.

Prints can be obtained on loan from Wyeth Film Library, Box 8299, Philadelphia 19101.

Dr. Ferree Retires

Dr. John W. Ferree, graduate of Indiana University School of Medicine and at one time Indiana State Health Commissioner, retired on September 1 as executive director of the National Society for the Prevention of Blindness, a post he had held for the past ten years.

Dr. Ferree will continue as a member of the National Eye Institute's Advisory Council and many other advisory and administrative positions with other organizations devoted to prevention and care of blindness.

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Dr. Bader Named



Dr. Joseph Bader, Indianapolis, has been promoted by Eli Lilly and Company to senior physician in clinical research international division. He is responsible for the pharmaceutical company's international antibiotics clinical research program and medical affairs in Southeast Asia, India, Pakistan, and South Africa. Dr. Bader joined Lilly's in 1966.

Dr. Province Re-Elected

Dr. William Province, Franklin, has been re-elected director-at-large of the National Tuberculosis Association. Dr. Province is the Johnson County Health Officer.

Dr. Chamblee Speaks

Dr. Roland Chamblee, South Bend, spoke on the history of the black man in America at a recent three-day Black Arts Review in South Bend.

Dr. Lampe Named

Dr. Elfred H. Lampe, Fort Wayne, has been named community chairman of the Obstetrics and Gynecology Committee under the Indiana University Plan for Statewide Medical Education.

Rotary Speaker

Dr. Milton May, Laconia, spoke on the side-effects of drugs at a recent meeting of the Corydon Rotary Club.

Syntex Laboratories to Publish "The Family Planner" Newsletter

"The Family Planner," an eight-page newsletter of interest to family planning counselors, nurses, field workers, administrators and physicians will be published eight times yearly by Syntex Laboratories.

The publication will be non-commercial and will focus on the human side of family planning. It is available at no charge by writing Syntex Laboratories, Standard Industrial Park, Palo Alto, California 94304.

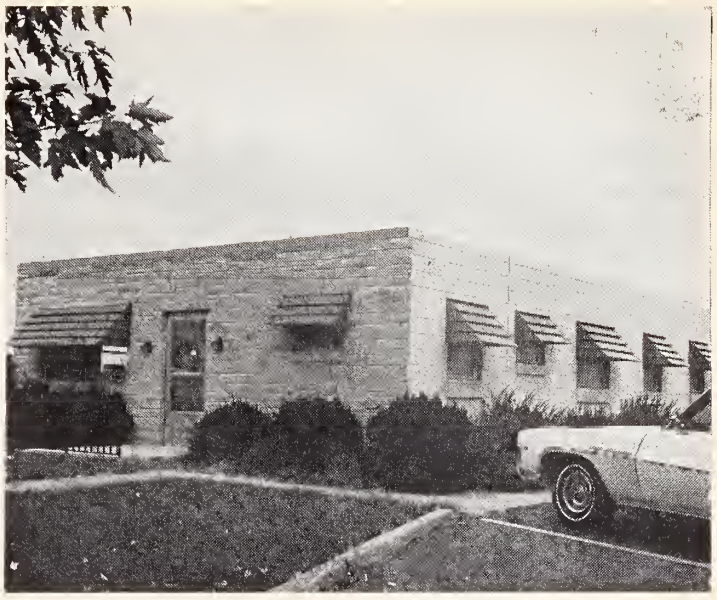
Seminar Speakers

Six Indianapolis physicians spoke at a recent seminar at Methodist Hospital on "Care of the Patient with Acute Myocardial Infarction." Speakers at the seminar, co-sponsored by the Indiana Heart Association and the Methodist Hospital Graduate Medical Center, were: **Drs. Jack H. Hall, William R. Storer, Warren E. Coggeshall, Morton E. Tavel, Richard R. Schumacher and Wendell L. Edwards.**

Physician Honored

Officials of Huntington County Hospital hosted an open house recently in honor of **Dr. Harold S. Brubaker** who had delivered his 5,000th baby. Dr. Brubaker started practice in Huntington in 1928 after taking his internship at St. Joseph's Hospital, Fort Wayne.

Continued



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or write Box 336, Silver Lake, Ind. 46982

NEWS NOTES

Continued

Dr. Garrett Presides

Dr. Robert A. Garrett, Indianapolis, presided over meetings of the Society for Pediatric Urology recently at the American Urological Association convention in San Francisco.

Volunteers Honored

Teenage volunteers from 38 schools in the Indianapolis area were honored recently at the 10th annual Teen Tonic ceremony sponsored by the United Cerebral Palsy of Central Indiana at the I.U. Medical Center. **Dr. Glenn W. Irwin, Jr.,** dean of the I.U. School of Medicine, spoke at the ceremonies.

Dr. Miller Speaks

Dr. John D. Miller, Indianapolis, spoke on tuberculosis recently before the Indiana Association of Osteopathic Physicians and Surgeons convention in Indianapolis. Dr. Miller is clinical director of the pulmonary disease section, Marion County General Hospital.

Visiting Nurses Meeting

Dr. Thomas J. Conway, Terre Haute, addressed the Visiting Nurse Association recently at their annual meeting in Terre Haute. He spoke about what is being done to reduce the mortality rate among infants, particularly the premature.

Dr. Bahr Honored

Dr. Robert Bahr, Fort Wayne, was cited as "Outstanding Alumnus" at the Fort Wayne Central High School Honors Banquet recently. He was presented with a gold plaque in "recognition of continued unselfish leadership and service to his community." Dr. Bahr addressed the honor students on the topic, "Are You Really Ready to Work?"

Dr. Howard Speaks

Dr. Joseph Howard, Logansport, and a local minister conducted father and son sex education courses recently in the Logansport Y. The course was offered for seventh and eighth grade boys and their fathers. Dr. Howard talked about the physiological aspects of sex.

Women's Circle Speaker

Dr. Sylvia Cheng, Walton, physician at Logansport State Hospital, spoke recently at a meeting of the Union Presbyterian Women's Club. Dr. Cheng spoke on the family relationships from childhood through old age.

Installed as Fellow

Dr. Frank M. Sturdevant, Portage, has been installed as a Fellow of the American College of Obstetricians and Gynecologists.

Dr. Covey Named

Dr. Thomas J. Covey, Valparaiso, has been elected to Fellowship in the American Academy of Pediatrics.

Dr. Emerson Named

Dr. James L. Emerson, a native of Indiana and a graduate of the Veterinary College of Ohio State University, has joined the Human Health Research and Development Laboratories of The Dow Chemical Company as a pathologist. He was recently an instructor at Purdue University where he received the M.S. and Ph.D. degrees.

Dr. Drake Speaks

Dr. James R. Drake, Anderson, spoke recently on diabetes at a program on this disease sponsored by St. John's Hospital there.

Dr. Neale is Speaker

Dr. Alfred E. Neale, Anderson, was guest speaker at a seminar for engaged couples recently at Park Place Church of God there. His topic was "Sexual Fulfillment in Marriage."

Dr. Weinberg Speaks

Dr. B. A. Weinberg, Whiting, addressed the Pope John XXIII Knights of Columbus Council recently at Whiting. He discussed "Aspects of Health Preparation for Retirement."

Dr. Shumacker Gives Talk

Dr. Harris B. Shumacker, Indianapolis, discussed the ethics of heart transplants during two services at the All Souls Unitarian Church recently. Dr. Shumacker is leading a team which is developing a totally implantable artificial heart.

The American Board of Family Practice announces that it will give its FIRST examination for certification in various centers throughout the United States. The examination will be over a two-day period on February 28-March 1, 1970. Information regarding the examination and eligibility for the examination can be obtained by writing:

Nicholas J. Pisacano, M.D., Secretary
American Board of Family Practice, Inc.
University of Kentucky Medical Center
Annex #2, Room 229
Lexington, Kentucky 40506

Speaks to Group

Dr. James Dimmett, Chandler, spoke on "Geriatrics" recently at the Southwest Indiana District Dietetic Association's meeting in Evansville.

Dr. Warvel Addresses Group

Dr. John H. Warvel, Jr., Kokomo, addressed members of the Howard County Diabetes Society recently in St. Joseph Memorial Hospital there. He spoke on "Current Treatment of Diabetes."

Gives Sex Talk

Dr. Lillian Holdeman, coordinator of Health, Health Education and Psychological Services of the South Bend Community Schools Corporation, spoke recently before the South Whitley PTA. Her topic was "Sex Education in the Public Schools."

Dr. Rawlins Speaks

"The Nursery Trip: Mother, Father and Baby" was the topic chosen by **Dr. Carolyn Rawlins, Munster,** when she spoke at a public meeting recently sponsored by the La Leche League in Valparaiso.

Dr. Williams Honored

Dr. A. S. Williams, Lake County Coroner, was named "Mr. Democrat, 1969" recently by the Lake County Young Democrats. Dr. Williams began his second term as coroner this year.

Dr. Loh Named

Dr. Wei-Ping Loh, Gary, was chairman of the judging committee for scientific exhibits at the 1969 convention of the Indiana State Medical Association held in Indianapolis. Dr. Loh has won scientific awards consecutively at previous conventions for the past three years and was the first place winner in 1968.

Director Re-Assigned

John L. McParland, who served as director of the VA Hospital at Fort Wayne from 1962 to 1967 has now been assigned to head the VA center in Wadsworth, Kansas. Since 1967 he has been director of the Chicago VA Research Hospital. ◄



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High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available

Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.

Assistant Professor of Psychiatry and Medical Director

Area Code 704-254-3201

Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION ANNUAL CONVENTION
Date June 21-25
Place Chicago, Ill.

NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville

INDIANA ROENTGEN SOCIETY, INC.
Date March 1, 1970
Place Holiday Inn East, Indianapolis

INDIANA ACADEMY OF GENERAL PRACTICE
Date April 14-16, 1970
Place Indianapolis

INDIANA DENTAL ASSOCIATION
Date May 13-16, 1970
Place Indianapolis Hilton Hotel, Indianapolis

INDIANA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS
Date May 6-7, 1970
Place Stouffer's Inn, Indianapolis

INDIANA SOCIETY OF ANESTHESIOLOGISTS
Date May 23, 1970
Place Marott Hotel, Indianapolis

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date May 6-8, 1970
Place Morris Inn, South Bend

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 12-15, 1970
Place South Bend

INDIANA PUBLIC HEALTH ASSN., INC. & INDIANA TUBERCULOSIS ASSN. JOINT MEETING
Date April 21-23, 1970
Place Stouffer's Indianapolis Inn

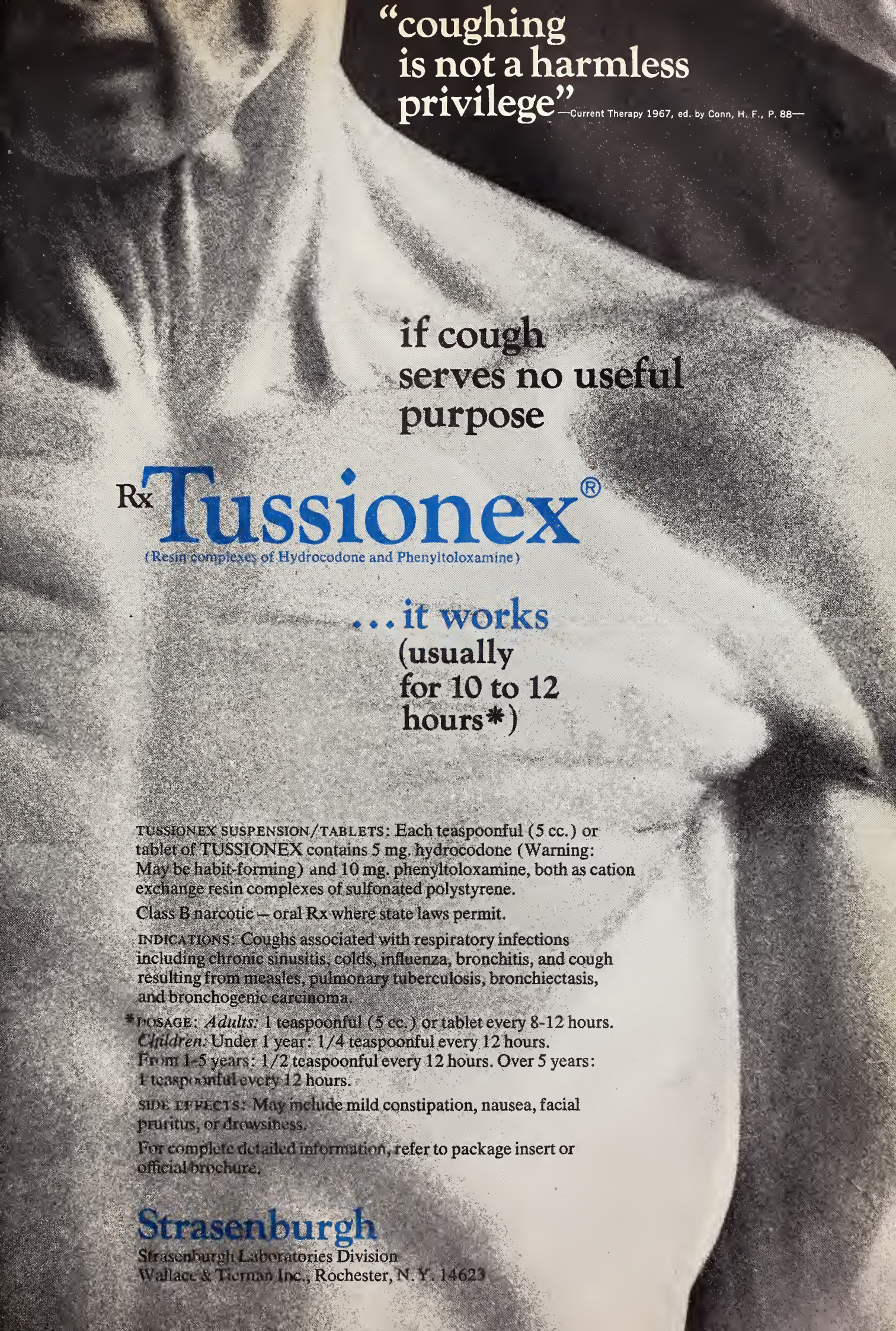
AMERICAN COLLEGE OF SURGEONS, INDIANA CHAPTER
Date April 16-18, 1970
Place Indiana State University, Terre Haute

INDIANA ASSOCIATION OF PATHOLOGISTS
Date December 5, 1970
Place Indianapolis Motor Speedway Motel, Indianapolis

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TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.

Class B narcotic – oral Rx where state laws permit.

INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

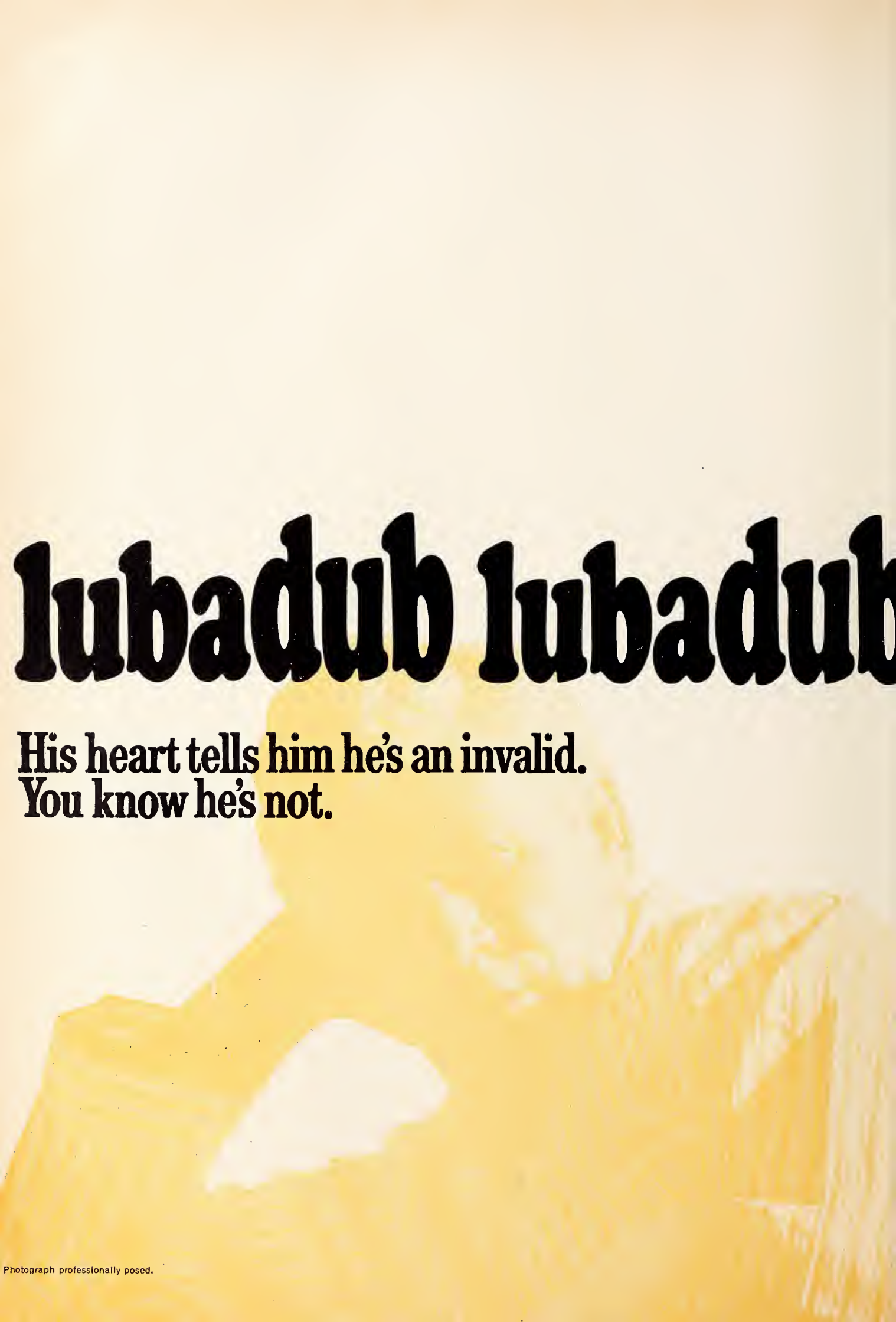
For complete detailed information, refer to package insert or official brochure.

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lubadub lubadub

His heart tells him he's an invalid.
You know he's not.



Photograph professionally posed.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis,

ubadubdub lubadu

Anxiety is expected in the cardiovascular patient. A little may even be desirable.

But when anxiety is exaggerated . . . when it interferes with sleep . . . when it aggravates cardiovascular symptoms, your help may be needed.

Naturally, you'll want to reassure the patient.

And perhaps prescribe Equanil (meprobamate) as adjunctive therapy. It helps relieve anxiety and tension specifically, yet gently.

Almost 15 years' use has shown that Equanil is usually well tolerated as well as effective. Side effects are generally limited to transient drowsiness; serious, therapy-interrupting side effects are rare.

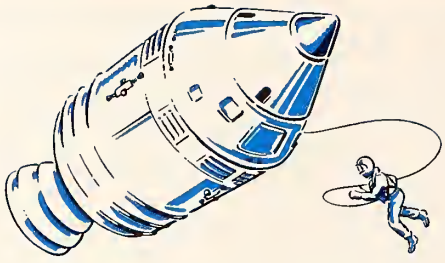
stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

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Equanil®
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Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

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Deaths

George C. Congleton, M.D.

George C. Congleton, 87, retired eye, ear, nose and throat specialist, died Sept. 10 in Cleveland, Ohio.

Dr. Congleton, who retired six years ago, was a former resident of Terre Haute and a past president of the Vigo County Medical Society.

John P. Gentile, M.D.

Dr. John P. Gentile, Jeffersonville physician and health officer for New Albany-Floyd County Health Department, died Oct. 28 at the age of 69.

A veteran of both World War I and World War II, Dr. Gentile served in the latter war as a medical officer after being graduated from the University of Louisville School of Medicine. Dr. Gentile was named secretary of the New Albany Board of Health in 1937. In 1964, when the Floyd and Harrison county health departments were merged into the New Albany-Floyd County Health Department, he was named its head.

Dr. Gentile was also a past president of the Floyd County Medical Society, served several terms as president of the Floyd County Tuberculosis Association and had been secretary of the New Albany Board of Health.

John L. Langohr, M.D.

Dr. John L. Langohr, Columbia City physician and surgeon, died Sept. 20 in Whitley County Memorial Hospital. He was 56.

Graduated from Wayne State University in 1940, Dr. Langohr served his internship and residency and then went to Boston in 1943 where he served as instructor of surgery at the Harvard Medical School. In 1946 he went to Columbia City and founded the Linville Memorial Clinic, where he was serving as chief surgeon at the time of his death. He was also on the surgical staff of Whitley County Memorial Hospital and courtesy staff surgeon at the three Fort Wayne hospitals.

Dr. Langohr, a former member of the ISMA Commission on Medical Economics and Insurance, was also a former president of the Whitley County Medical Society.

James F. Lewis, M.D.

Dr. James F. Lewis, Union County health officer and a physician at Liberty since 1934, died Oct. 5. He was 64 years old.

Dr. Lewis, graduated from the I.U. School of Medicine in 1933, was a World War II veteran. He was a past-president of both the Wayne-Union County Medical Society and the Sixth District Medical Society; was a member of the Reid Memorial Hospital medical staff; an ISMA delegate for several terms and a member of the ISMA Commission on Constitution and Bylaws.

H. D. McCormick, M.D.

Dr. Hubert D. McCormick, Vincennes physician for 60 years, died Sept. 30 at the age of 86.

Dr. McCormick, an Indiana University Medical School graduate, served in the Army Medical Corps in World War I and was a member of the Knox County Medical Society. He was also a Senior Member of ISMA and member of the 50-Year Club.

Henry O. Mertz, M.D.

Dr. Henry O. Mertz, 85, retired urologist and professor emeritus of the I.U. School of Medicine, died Sept. 12 at Indianapolis.

An Indianapolis resident 46 years, Dr. Mertz lived in Atlanta, Ga., the last five years and returned to Indianapolis recently after becoming ill. A graduate of the I.U. School of Medicine in 1908, Dr. Mertz was both teacher and practitioner. He founded the school's department of urology in 1936, and headed the department from that time until he retired in 1952.

A pioneer in the development of pediatric urology, he established the state's residency training program in urology at the medical center and was a staff member of all the Indianapolis hospitals at the time of his retirement. Dr. Mertz was a member of the Marion County Medical Society, a Senior Member of ISMA and member of the 50-Year Club.

Hugh A. Vore, M.D.

Dr. Hugh A. Vore, 74-year-old retired East Chicago schools physician, died Oct. 27 at Warsaw.

Dr. Vore, who served in the school system for 19 years, was graduated from the University of Michigan School of Medicine in 1926. Following retirement from the East Chicago schools, Dr. Vore served six years as a physician for the Inland Steel Corp., East Chicago. He also was a medical examiner for the East Chicago Selective Service office; a World War I veteran; a Senior Member of ISMA and member of the Lake County Medical Society. ◄

County, District News

Allen

Dr. David H. Knott and James D. Beard, Ph.D., of the University of Tennessee, discussed "Alcoholism" at the Oct. 7 meeting of the Allen County Medical Society. One-hundred and thirty physicians and wives attended the meeting.

Boone

New officers of the Boone County Medical Society are: Drs. Don W. Boyer, president; Thornton Perkins, vice-president and Kathryn A. Jackson, secretary-treasurer. Drs. Boyer and Perkins are from Lebanon and Dr. Jackson from Zionsville.

Dearborn-Ohio

Dr. Juan Ortiz, anesthesiologist at Dearborn County Hospital in Lawrenceburg, spoke at the Oct. 2 meeting of the Dearborn-Ohio County Medical Society. He discussed the Dominican Republic, his native land.

Elkhart

The Oct. 2 meeting of the Elkhart County Medical Society featured a Cancer Symposium on the Head and Neck, sponsored by the Indiana Academy of General Practice. Speakers were from the I.U. School of Medicine.

Marion

Dr. John O. Butler is the new president of the Marion County Medical Society. Other new officers include: Drs. A. Alan Fischer, vice-president; Donald E. Stephens, president-elect and Malcolm L. Wrege, secretary-treasurer. All of the new officers are from Indianapolis.

Montgomery

"Drug Abuse or the Whole World is Going to Pot" was the topic of Dr. H. Frank Fraser, Indianapolis, when he spoke at the Oct. 23 meeting of the Montgomery County Medical Society.

Putnam

Dr. Jack G. Weinbaum, Terre Haute, spoke on "Tests of Thyroid Function" at the Oct. 10 meeting of the Putnam County Medical Society.

Sullivan

New officers of the Sullivan County Medical Society for the coming year are: Drs. K. W. Eskew, Sullivan, president; W. H. Daugherty, Hutsonville, Ill., vice-president and J. S. Brown, re-elected secretary-treasurer.

Wells

The Wells County Medical Society met Oct. 27 in Bluffton to discuss the "Mantoux Test for Teachers" and appoint a nominating committee for 1970 officers, among other business. ◄

A hospital for the diagnosis and treatment of psychiatric illness

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Alfred R. Heasty, M.D.	

Robert K. Jones, Ph.D.
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Mrs. Margaret Keedy, A.C.S.W.
Psychiatric Social Worker

Elizabeth J. Snyder, R.N.
Director of Nursing Service

James Jones, B.P.E.
Director of Activity Therapy

Donald R. Kinzer, Hospital Administrator

John Sterzer, Business Manager

Admissions are arranged through referral to any active staff psychiatrist.

All general medical and surgical specialties in the community are available through physicians on the open consulting staff.



1969 - The Convention Story



THE BOARD OF TRUSTEES met Monday afternoon and every morning to labor over business matters.



THE EXECUTIVE COMMITTEE also met Monday during convention.



THE ANNUAL Trustees Dinner was held at the Atkinson Hotel this year.



MRS. PATRICK J. V. CORCORAN, Dr. Lowell H. Steen and Mrs. Donald R. Taylor chat during the Annual Trustees Dinner Monday night.



MRS. KENNETH D. SCHNEIDER, president of the woman's auxiliary, addressed the House at its first meeting Tuesday.



THE HOUSE OF DELEGATES met Tuesday morning in the Ballroom of the Columbia Club.



DR. M. B. GOSSARD, Tipton, tees off at the annual golf tournament Tuesday morning at Hillcrest Country Club. Waiting their turns are (left to right) Drs. W. A. Kurtz, Tipton; W. D. Dannacher, Wabash and G. L. Compton, Tipton.



DR. A. ALAN FISCHER, Indianapolis, was chairman of Reference Committee No. 2 which met in the Basement Dining Room of the Murat Temple.



LT. COL. FRANK R. CAMP, Jr., Fort Knox, Ky., and Dr. Harold S. Kaplan, St. Louis, Mo., compare notes before speaking on Problems in Blood Banking and Transfusion Therapy Tuesday afternoon in the Egyptian Room.



LT. COL. CHARLES E. SHIELDS, Fort Knox, Ky., also addressed the special session.



THE ANNUAL dinner meeting for Women Physicians of Indiana was held at the Athletic Club this year. Dr. Frances T. Brown, Indianapolis, spoke on "Tahiti and the South Seas."



FIRESIDE CONFERENCES on Current Therapy featured a discussion on Current Therapy in Contraception Tuesday night at the Columbia Club.



THE ORIENTATION Meeting for new members was held in the Egyptian Room of the Murat Temple on Wednesday morning.



THE SECTION ON CUTANEOUS MEDICINE sponsored a special dermatology clinic at General Hospital for the first time. Dr. Patrick Logan, Indianapolis, is at the microscope, while Dr. Stephen Phelps, South Bend and Dr. Malcolm C. Spencer, Danville, Ill., await their turn.



DR. LEE B. STEVENSON, Detroit, Mich., addressed the Section on Obstetrics and Gynecology luncheon meeting Wednesday at the Athenaeum.



JOURNAL POLICY PLANNERS: The Editorial Board.



THE WOMAN'S AUXILIARY luncheon was Wednesday at the Woodstock Country Club.



FIRST SPEAKER at the General Meeting Wednesday afternoon was Robert L. Forste, Indianapolis medical student.



DR. SAMUEL SASLAW, Columbus, Ohio, spoke on "Recent Advances in Antibiotic Therapy" at the first General Meeting.



DR. HARVEY R. BERNARD, Albany, N.Y., also spoke at the General Meeting on Wednesday.



ROBERT E. WRENN, Indianapolis medical student, added his thoughts on the "Cardiac Conduction System" to the General Meeting.



ANOTHER General Meeting speaker was Dr. Eliot Corday, Los Angeles, who spoke on "Recent Advances in Cardiovascular Therapy."



DR. DAVID YI-YUNG HSIA, Chicago, Ill., was the final speaker Wednesday at the General Meeting in the Egyptian Room of the Murat Temple.



DR. AND MRS. GILBERT WILHELMUS, Evansville, join Dr. and Mrs. Robert E. Callan, Milwaukee, Wis., at the President's Reception Wednesday evening at the Columbia Club. Dr. Callan is president of the Wisconsin Medical Society.



MEMBERS of the 50-Year Club met prior to the President's Reception Wednesday evening in the Circle Room of the Columbia Club.



DR. LOWELL H. STEEN and Dr. Patrick J. V. Corcoran welcome former Rep. Charles Halleck to the President's Reception Wednesday night.



DR. STEEN adjusts the tie of Dr. Corcoran prior to the President's Dinner.



THE PRESIDENT'S RECEPTION started off the proceedings for the President's Dinner.



DR. AND MRS. CORCORAN and daughters pose for an "official family portrait" at the President's Reception.



OVERALL picture of the crowd which attended the President's Dinner in the Ballroom of the Columbia Club.



DR. OTIS BOWEN spoke at the President's Dinner Wednesday night.



DR. ROBERT P. ACHER, Greensburg, won first place in the scientific awards and also the Aesculapian award for his exhibit on "Prospective Medicine."



DR. BILL MARTZ accepts the second place scientific award for C. W. Godzeski, Ph.D., of the Lilly Laboratory for Clinical Research.



WINNERS of third place in the scientific exhibits were Drs. Robert E. Gerth and George B. Pratt, Jr., of Methodist Hospital.



DR. WALTER C. BORNEMEIER, president-elect of the AMA, presents the Humanitarian Service award to Dr. Paul M. Waitt for his volunteer service in Vietnam.



THE PHYSICIAN OF THE YEAR AWARD, presented by the Mental Health Association in Indiana, went to Dr. Donald M. Kerr, Bedford.



DR. LOREN H. MARTIN, Indianapolis, presents a check for $100,000 from the Indiana Medical Foundation to Dean Glenn W. Irwin, Jr., of the I.U. School of Medicine.



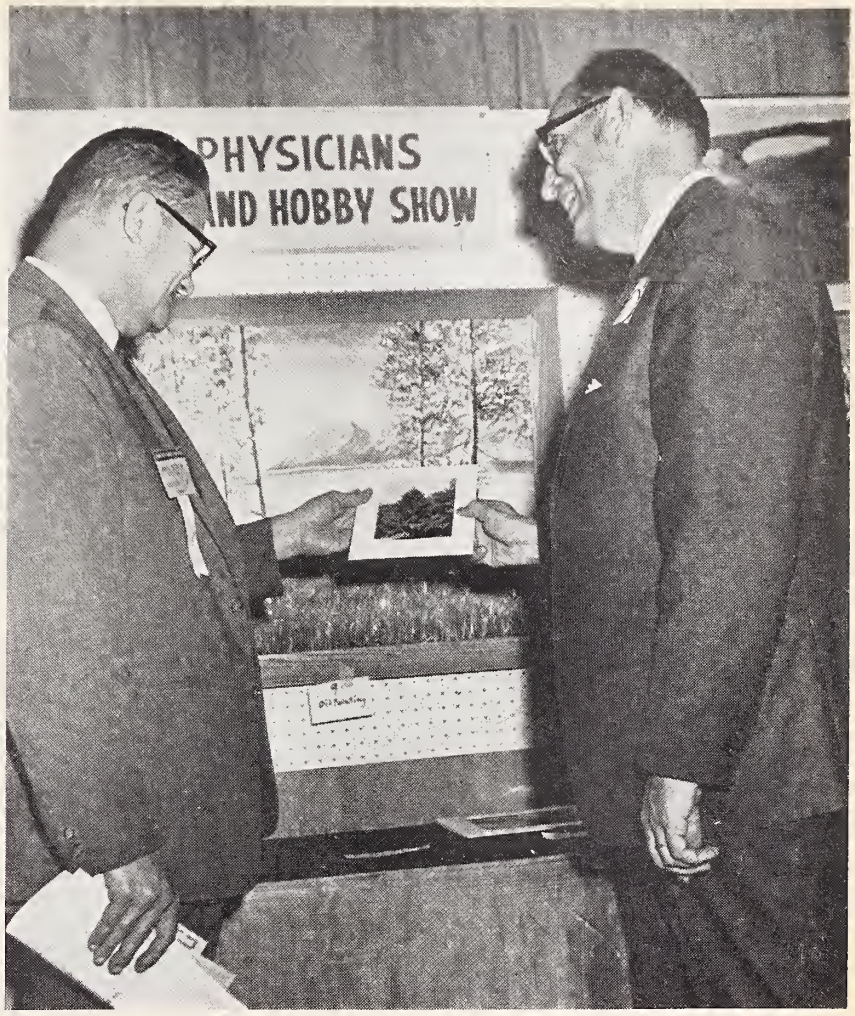
DR. STEEN presents the president's plaque to Dr. Corcoran, retiring president.



ENTERTAINMENT at the President's Dinner was provided by the Evansville North High School Choir.



PHYSICIANS jam the aisles in the technical exhibitors section.



DR. JOHN WILSON, Evansville, and Dr. Malcolm O. Scamahorn, Pittsboro, discuss one of the exhibits entered in this year's Art and Hobby Show.



THE MEDICO-LEGAL General Meeting Thursday morning was opened by Lawrence A. Jegen, III, L.L.M., who spoke on "Medical Legal Problems Both in Aspect of the Plaintiff and Defendant."



CLEON H. FOUST, dean of the Indiana University Indianapolis Law School, spoke on "The Tax Reform and You" at the Wednesday morning General Meeting.



"THE DOLLAR and Sense Existence of Malpractice Insurance" was the topic of Kenneth W. Moeller, Medical Protective Company, Indianapolis, at the General Meeting.



THE PAST PRESIDENT'S luncheon was held at the Athenaeum this year.



THE COLLEGE HEALTH PHYSICIANS held their first luncheon meeting this year on Thursday at the Athenaeum.



THE SMALL COUNTY DELEGATES met in the Foyer to the Candidates Room on Thursday afternoon.



FIRST SPEAKER at the Thursday afternoon General Meeting was Robert J. Cates, Indianapolis medical student.



DR. H. F. FRASER, Indianapolis, discussed "Managing the Patient who Takes Drugs" at the General Meeting in the Egyptian Room.



"MANAGEMENT of Acute Hand Injuries" was the topic of Dr. Harold Kleinert, Louisville, Ky., when he spoke before the General Meeting.



MEDICAL STUDENT Glenn J. Bingle, Indianapolis, also spoke at the General Meeting on "Electron Microscopic Studies of Myelination."



FINAL SPEAKER at the General Meeting was Dr. Edward A. Tyler, Indianapolis, who spoke on "The Patient with the Sex Problem."



DR. AND MRS. EZRA D. ALEXANDER, Indianapolis, arrive at the Murat Theatre Thursday evening for the performance of the Indianapolis Symphony Orchestra.



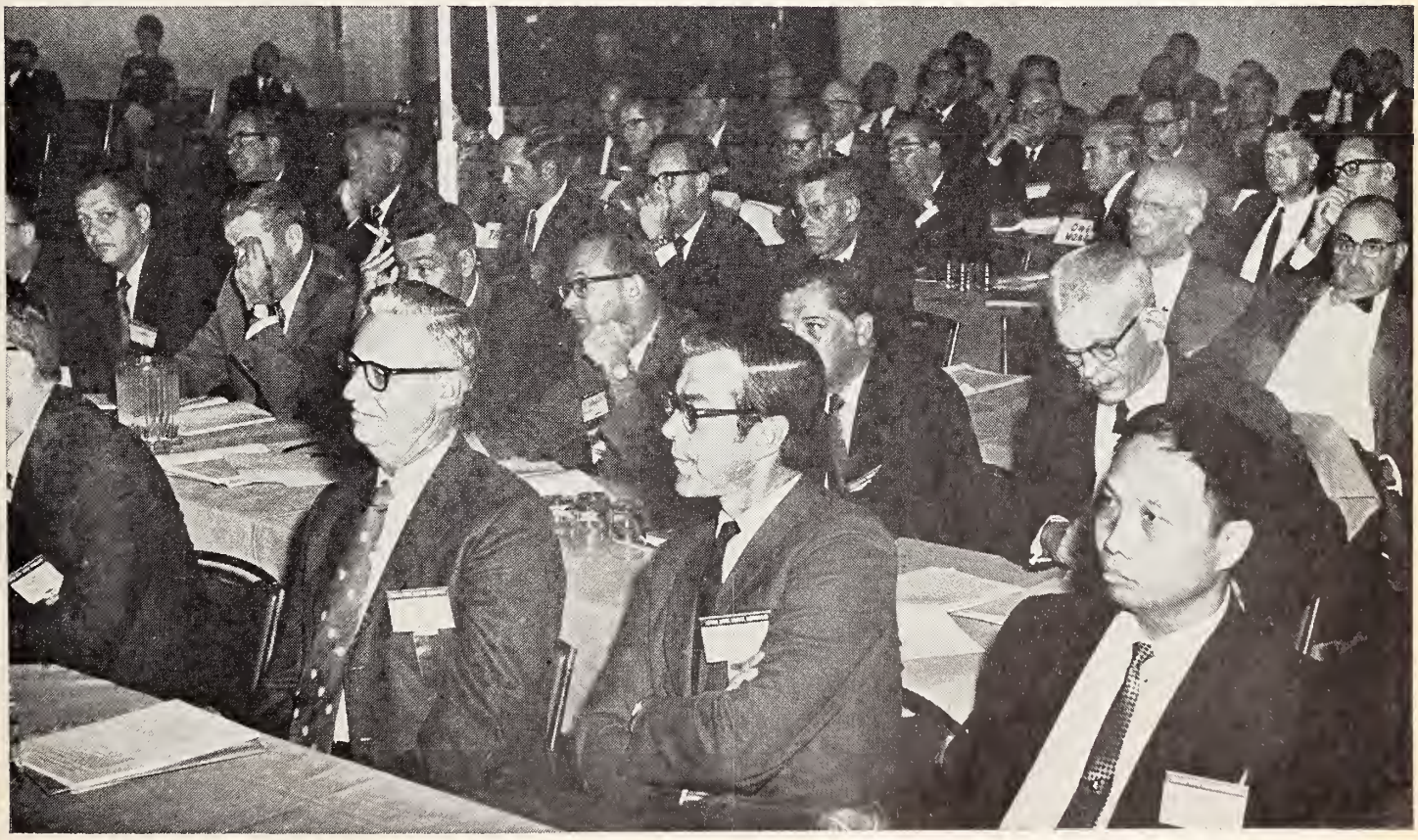
DR. AND MRS. LOWELL H. STEEN also attended the symphony performance.



DR. WALTER BORNEMEIER, president-elect of the AMA, addressed the House of Delegates on Friday morning.



DR. MALCOLM O. SCAMAHORN, newly-elected president-elect, addresses the House.



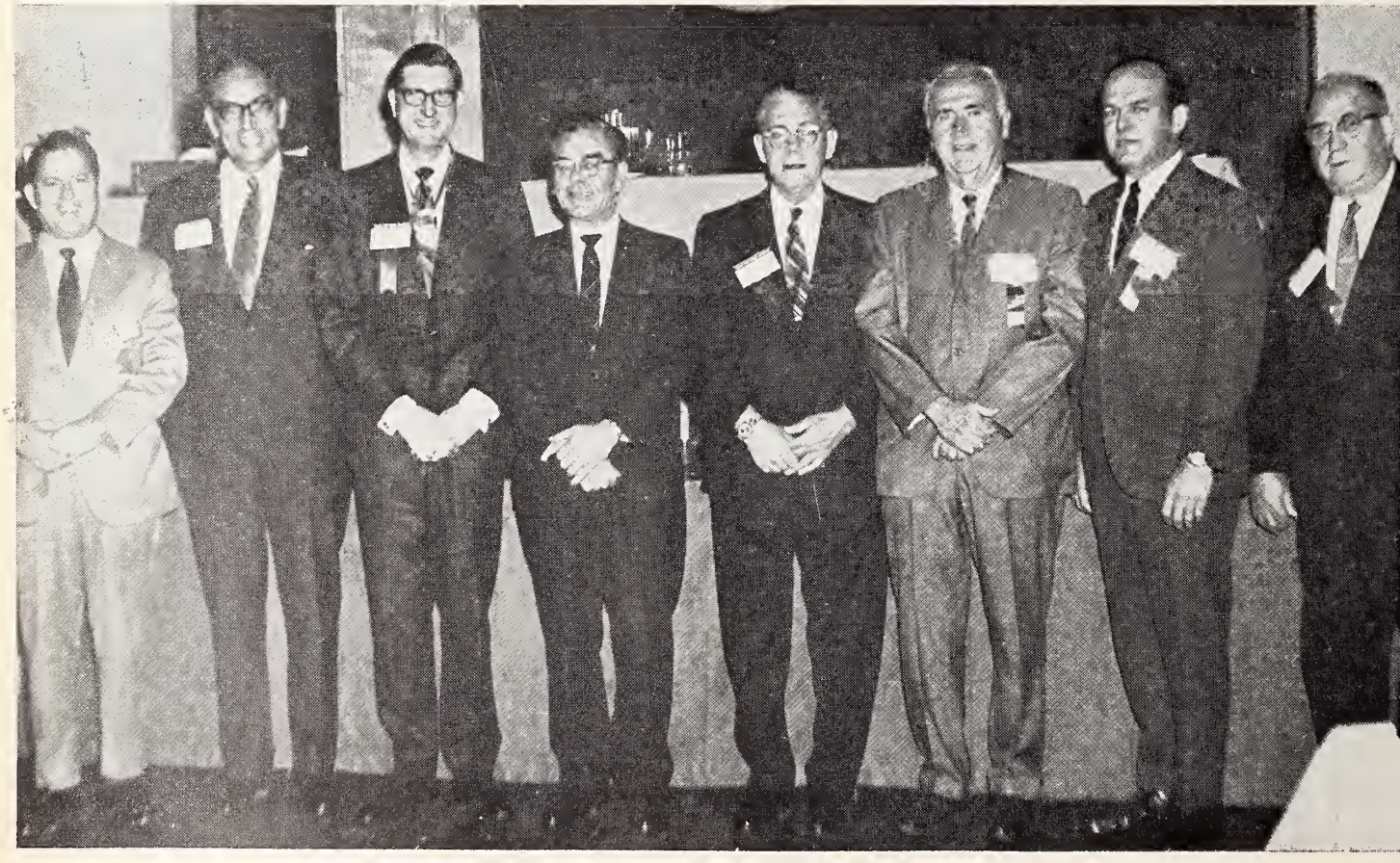
THE HOUSE OF DELEGATES met for its final session Friday morning in the Ballroom of the Columbia Club.



DR. STEEN congratulates Dr. Scamahorn on his election.



DR. CORCORAN admires the presidential medallion he ha placed around Dr. Steen's neck.



THE NEW OFFICERS of the association are shown after being sworn into office.

Convention Election Results:

Dr. Malcolm O. Scamahorn Named President-Elect

Dr. Malcolm O. Scamahorn, Pittsboro general practitioner, was elected president-elect of the Indiana State Medical Association at the closing session of the House of Delegates in October.

A 1943 graduate of the Indiana University School of Medicine, Dr. Scamahorn has practiced in Pittsboro since 1946.

Active in organized medicine for a number of years, he has been president and secretary of the Hendricks County Medical Society and delegate and alternate delegate to the Indiana State Medical Association House of Delegates.

In the state organization Dr. Scamahorn has served as assistant treasurer, secretary of the Commission on Voluntary Health Agencies, chairman of the Commission on Voluntary Health Agencies, chairman of the Commisison on Special Activities and chairman of several ISMA Reference Committees during state conventions.

Dr. Scamahorn is also a member of the American and Indiana Academies of General Practice where he has served as delegate, chairman of the General Practice Club for medical students and the Preceptor Committee, a committee also directed toward student training.

He was the first chief-of-staff at the Hendricks County Hospital and is a member of the staff of Methodist Hospital in Indianapolis. He has been president of the Hendricks County Board of Health, deputy coroner and a member of the Township Advisory Board.

Also taking office during the convention were Drs. Lester H. Hoyt, Indianapolis, re-elected treasurer; Hugh K. Thatcher, Jr., Indianapolis, elected assistant treasurer and Peter R. Petrich, Attica, elected chairman of the Board of Trustees. Dr. Donald M. Kerr, Bedford, was elected chairman of the Executive Committee and Dr. Burton E. Kintner, Elkhart, was re-elected to the Executive Committee.

Dr. Jack Shields, Brownstown, was re-elected as delegate to the American Medical Association and Dr. John Farquhar, Fort Wayne, was also elected AMA delegate. Elected alternates were Drs. Patrick J. V. Corcoran, Evansville and Thomas C. Tyrrell, Calumet City, Ill.

Taking over their official duties as new trustees for their district at the convention were: Drs. Joe Dukes, Dugger, Second District; Wilbert McIntosh, Riley, Fifth District; Richard Ingram, Montpelier, Eighth District and Lowell Hillis, Logansport, Eleventh District.

Elected alternate trustees were: Drs. John O. Butler, Indianapolis, Seventh District and Thomas C. Tyrrell, Calumet City, Ill., Tenth District.

Results of the various section elections are as follows:

Section on Surgery: Chairman—Austin Gardner, Indianapolis; Vice-chairman—Robert Rang, Washington; Secretary—Joe G. Jontz, Fort Wayne.

Section on Internal Medicine: Chairman—Evart M. Beck, Indianapolis; Vice-chairman—D. Edmund Storey, Indianapolis; Secretary—Berj Antreasian, Indianapolis.

Section on Ophthalmology and Otolaryngology: Chairman—Alvin L. Henry, Columbus; Vice-chairman—William C. Schafer, Washington; Secretary—David L. Alvis, Indianapolis.

Section on Anesthesiology: Chairman—Jerry R. Miller, Indianapolis; Vice-chairman—Everett Donnelly, South Bend; Secretary—John H. Smith, Greenfield.

Section on General Practice: Chairman—Warren McClure, Kokomo; Vice-chairman—Robert Acher, Greensburg; Secretary—James T. Anderson, Greenfield.

Section on Obstetrics and Gynecology: Chairman—Charles R. Echt, Indianapolis; Vice-chairman—Barton T. Smith, Marion; Secretary—Jerome F. Doss, Kokomo.

Section on Public Health and Preventive Medicine: Chairman—Lester L. Renbarger, Marion; Vice-chairman—Henry G. Nester, Indianapolis; Secretary—Louis E. How, South Bend.

Section on Radiology: Chairman—Robert E. Beck, Evansville; Vice-chairman—Marvin N. Golper, Kokomo; Secretary—Dale B. Parshall, Elkhart.

Section on Nervous and Mental Diseases: Chairman—Stanley Hammond, Munster; Vice-chairman—John I. Nurnberger, Indianapolis; Secretary—Wesley A. Kissel, Indianapolis.

Section on Pathology and Forensic Medicine: Chairman—Harley P. Palmer, Franklin; Secretary—Robert L. Costin, Indianapolis.

Section on Pediatrics: Chairman—George F. Parker, Indianapolis; Vice-chairman—Wendell E. Brown, Indianapolis; Secretary—Donald L. Rogers, Indianapolis.

Section on Directors of Medical Education: Chairman—Donald T. Olson, South Bend; Vice-chairman and Secretary—Franklin A. Bryan, Fort Wayne.

Section on Cutaneous Medicine: Chairman—Paul V. Chivington, Jr., Indianapolis; Vice-chairman—Jere D. Guin, Kokomo; Secretary—Howard R. Gray, Indianapolis. ◄

THE WINNERS—120th Annual Convention Indianapolis, Oct. 13-17, 1969

MEN'S ART AND HOBBY SHOW

Oil Painting:

First: Charles P. Schneider, M.D., Evansville
Second: T. T. Suzuki, M.D., Covington
Third: Dr. Suzuki

Honorable Mention:

Raymond Burnikel, M.D., Evansville
Robert E. Hannemann, M.D., Lafayette
Dr. Burnikel
S. O. Waife, M. D., Indianapolis
Dr. Suzuki
Carl M. Davis, M.D., Valparaiso

Watercolor Painting:

First: C. L. Patterson, M.D., Evansville

Drawing:

First: Robert H. Terry, Boonville

Photograph—Black and White:

First: Walter Dykus, M.D., Evansville
Second: Dr. Dykus
Third: Dr. Dykus

Honorable Mention:

Dr. Dykus

Photograph—Color:

First: Robert E. Hannemann, M.D., Lafayette
Second: Philip T. Holland, M.D., Bloomington
Third: Dr. Holland

Honorable Mention:

Dr. Holland

Sculpture:

First: Jack W. Hickman, M.D., Indianapolis

Craft—Other than Sculpture:

First: Charles P. Schneider, M.D., Evansville

Collection or Hobby:

First: William Ritchie, M.D., Evansville

Special Exhibit:

First: William Ritchie, M.D., Evansville
Second: Robert Terry, M.D., Boonville

Handicraft:

First: William Ritchie, M.D., Evansville
Second: Robert H. Terry, M.D., Boonville

WOMAN'S AUXILIARY ART AND HOBBY SHOW

Oil Painting:

First: Mrs. J. D. Wilson, Evansville
Second: Mary Lois Miller, Elkhart
Third: Mrs. J. D. Wilson

Honorable Mention:

Mary Lois Miller, Elkhart

Craft—Other than Sculpture:

First: Mrs. Ray Burnikel, Evansville
Second: Mrs. Lou Young, Evansville
Third: Mrs. Burnikel

Handicraft:

First: Mrs. Muriel J. Ritchie, Evansville
Second: Mrs. Ritchie

SCIENTIFIC EXHIBIT AWARD WINNERS

Award No. 1—Robert P. Acher, M.D., Greensburg; Lewis C. Robbins, M.D., Indianapolis—PROSPECTIVE MEDICINE.

(Drs. Acher and Robbins were also awarded the Aesculapian Award, sponsored by Eli Lilly & Company).

Award No. 2—C. W. Godzeski, Ph.D., Lilly Laboratory for Clinical Research, Marion County General Hospital, Indianapolis—POSSIBLE CAUSE OF PERSISTENT INFECTIONS.

Award No. 3—Robert E. Gerth, M.D.; George B. Pratt, Jr., M.D., Indianapolis—RESPIRATORY DISTRESS IN THE NEWBORN AND PREMATURE.

MEN'S GOLF TOURNAMENT

Low Gross—Joseph E. Ball, M.D., Indianapolis
Second Low Gross—Norman K. Wilson, M.D., Kokomo

(The remainder of the prizes were awarded on the basis of Banker's Handicap).

Minutes of the House of Delegates

1969

CREDENTIALS COMMITTEE REPORT 1478

ADDRESS OF THE PRESIDENT 1478

PRINTED REPORT OF THE PRESIDENT 1479

IN MEMORIAM 1480

1968 MINUTES 1480

1969 REFERENCE COMMITTEES 1480

AMENDMENTS TO THE CONSTITUTION 1481

PRESIDENT-ELECT'S ADDRESS 1481

PRINTED REPORT OF THE PRESIDENT-ELECT 1484

WOMAN'S AUXILIARY PRESIDENTIAL ADDRESS 1485

REPORT OF INDIANA STUDENT AMA 1486

REPORT OF CHAIRMAN OF BLUE SHIELD BOARD OF DIRECTORS 1488

REMARKS OF WALTER C. BORNEMEIER, M.D. 1488

ELECTION OF OFFICERS 1489

REPORTS OF OFFICERS 1489

- Executive Secretary 1489
- Treasurer 1491
- Chairman of the Board 1496
- Trustees 1497
- Editor of The Journal 1502
- Delegates to AMA 1502

STATE BOARD OF MEDICAL REGISTRATION AND EXAMINATION 1507

REPORTS OF STANDING COMMITTEES AND COMMISSIONS 1508

- Executive 1508
- Grievance 1510
- Student Loan 1510
- Medical-Legal Review 1510
- Future Planning 1511
- Sports and Medicine 1511
- Medicine and Religion 1511
- Constitution and Bylaws 1512
- Legislation 1513
- Public Information 1516
- Governmental Medical Services 1516
- Public Health 1517
- Voluntary Health Agencies 1527
- Medical Economics and Insurance 1528
- Medical Education and Licensure 1529
- Special Activities 1529
- Aging 1530
- Emergency Medical Services 1531

RESOLUTIONS 1532

PLACES OF FUTURE ANNUAL CONVENTIONS 1539

ADJOURNMENT 1539

House of Delegates Proceedings

INDIANAPOLIS SESSION
October 13-17, 1969

The first meeting of the House of Delegates convened at 10 a.m. Tuesday, October 14, 1969, in the Ballroom of the Columbia Club, Indianapolis, Indiana, with Dr. Patrick J. V. Corcoran, president of the Indiana State Medical Association, presiding.

The second and final meeting of the House was convened on Friday morning, October 17 at 9 a.m. in the Ballroom of the Columbia Club at Indianapolis.

Report of the Credentials Committee

For the first meeting of the House of Delegates the Credentials Committee reported 77 delegates in attendance. At the final session the report was 118 delegates, 10 trustees and 6 past presidents. The chair announced that inasmuch as 50 constitutes a quorum, there was a quorum present for both sessions of the House.

Address of the President

The following remarks were presented by Dr. Patrick J. V. Corcoran on Tuesday, October 14, 1969.

HOUSE ACTION: Approved. The Reference Committee urged that the recommendations be referred to the Board of Trustees for their assignment to the appropriate commission or committee for study or action where indicated.

At this time it is my privilege to inflict a speech upon you which I will address to the members of the House and guests. My report as president is already in your hands—printed in the Handbook—to conserve our time in this meeting and in order to have provided you with an opportunity for unhurried consideration of the proposals.

In previous communications, I have discussed the purposes and the justification of our association. Securing the best levels of health—physical, mental, and environmental—is our major concern.

In our day-to-day functioning, much attention has to be given to organizational housekeeping matters and administrative details. I have also been concerned with concepts and the broad over-view of our place in the scheme of things. I believe we must constantly develop attitudes and relationships that will put our association into a position to realize its greatest potential and to achieve its fullest effectiveness.

Ours should be the primary professional organization of all physicians. We should make room for and welcome into our ranks all eligible doctors of medicine; we should be responsive to their needs, representative of their attitudes, and have activities relevant to their goals. Full participation by all members will strengthen the association and enhance its thrust in speaking for the doctors of Indiana. It should be the umbrella which shelters us all.

If any segments of the profession are, in effect, functionally excluded, we decrease our impact and dismember our representative body.

We must remain attuned to the times and not irrevocably committed to ideas that can disengage portions of our membership.

The accessibility of quality health care to everyone, equitably when it is needed, is a major objective. We should judge our activities in relation to this. The ultimate decisions concerning the forms of health care and services will be made by the American public. This choice will be influenced by factors of necessity, economics, emotions and social viewpoints related to current styles and popular attitudes. Our efforts must be to persuade our fellow citizens to seek goals of the best quality and the most effective methods.

We can respond to the criticism that periodically is directly upon us if we understand the factors which produce it.

Changes have been more marked during the past 50 years than at any time in the whole record of mankind. Since the last meeting of this House, men have left the earth to enter the solar system and to return. Comparable departures from time-honored patterns are taking place in many other aspects of our lives. In no other field have these been any greater than they have been in that of health. We must chart new pathways with imagination and purposeful determination.

Many of these new developments reach to the very core of life itself and have altered patient-doctor relationships, especially since the advent of an avalanche of potent methods of treatment, the social effects of World War II and its sequels, and a steadily growing welfare state philosophy.

Our patients now expect prompt and effective medical care, scientifically oriented, rather than the reassurance of a fatherly physician.

These *expectations* of instant results are not always uniformly realized due to the limitations of present-day capabilities of an overworked and undermanned health care system.

These frustrations can provoke dissatisfaction which sometimes erupts into criticism of doctors.

The shortage of health manpower will probably be with us during all of our professional lifetime. We will need constantly to reappraise our own responsibilities and our limitations and adapt them to the rapidly changing scene.

The health manpower shortage can be at least partially relieved by measures to spread physicians' work loads most equitably among us and to expand our present capabilities by increased instrumentation and by extension through forms of delegation to ancillary personnel. This may involve shared responsibilities and team relationships for physicians as well as allied health professionals. We must delineate these interrelationships with care and precision.

The distribution of physicians is being steadily maladjusted by the decreasing proportion of those who are undertaking the primary care of patients.

The highly trained professional is unlikely to isolate himself in a location away from the stimuli of equally trained colleagues and of a culturally attractive environment. He will avoid the servitude of an unremitting work schedule which debilitates him and alienates his family. His motivations will stem from incentives, which for the physician are status and recognition within the profession, suitable working, living, and recreational conditions and satisfaction for family and self.

The very highest quality of professional services must be fostered. This may be done through continuing education, self-assessment programs, peer review, and disciplinary mechanisms. Our president-elect is knowledgeable in these matters and will, I am sure, provide vigorous leadership in carrying them forward during the coming year.

An Advisory Committee on Health Care was authorized by the Board of Trustees over a year ago. I appointed such a committee of fellow Hoosiers, all of them non-physicians, last spring. They accepted the challenge with enthusiasm and have been working diligently, without supervision from me. A preliminary report received during the past week is as follows:

"The committee is not yet ready to make a full report. It has attempted to

acquaint itself with the whole broad range of health care services, costs, trends and problems. It is examining the issues only from the standpoint of lay observers analyzing the delivery of health care services. Three major subjects are being studied.

1. Health manpower.
2. Distribution of health services.
3. Developments to be examined for possible future improvements in the health care system."

The committee plans to address itself to the long-range question of the role of the physician as a leader in a time of change. Their comments will be those of lay members of society as they view our profession. They further indicate that they are learning a great deal and appreciate the opportunity. They hope their final conclusions will be of some value to the association as it deals with the same issues.

Our countrymen look to us for leadership in many matters, especially those with a medical or a biological focus, or which impinge on the social or moral fabric of our society. We should formulate ways to shape attitudes on the subjects of pollution of our environment, the use of drugs, sexual standards, and the portrayal of violence or deviate behavior in forms of entertainment. We should be able to offer well-founded recommendations regarding marijuana and psychedelic agents, especially with respect to their risks, addictiveness, and means of control. For this we need data of objective validity rather than mere opinions. Our state has rich resources upon which we could draw in order to get this information. There is a great pool of talent and knowledge within our own profession, our universities and our splendid pharmaceutical and industrial enterprises. We should not have to depend on our federal government entirely. We have our own near-at-hand means to undertake it, and we should, without delay. Our Commission on Public Information, in cooperation with our Commission on Public Health and our Committee on Medicine and Religion would appear to be the most appropriate group to do this.

In the field of social and economic matters, we have urgent need of valid, objective, current data, which is unbiased and beyond challenge. We need this first of all as a basis upon which to make decisions and to formulate our own policies. It is then equally needed to document any program in public relations or to use in negotiations which we may have to undertake.

Therefore, I recommend that we promptly establish within our association a Division of Socio-Economics and Health Care Data. This could then play a vital role in generating the information and in providing materials on which we depend for almost every feature of our activities.

Our concern for the poor and the disadvantaged should be highly evident. We should be alert for every opportunity whereby we can work to improve their situation. The factors which can produce deficiencies of health care in the slums and ghettos are too many and too complex to discuss here. Moreover, these problems are primarily social in nature and involve issues larger and broader than health care alone. We must actively cooperate in doing all we can to correct any inequities as promptly as possible, both as professionals and as enlightened citizens.

This House is the supreme authority in the association. It is in session four days out of 365. Therefore, it must establish guidelines and policies to be carried out by the officers, the commissions, and the committees.

Among the most important decisions which you make are your selection of the officers and our delegates to the AMA.

The caliber of our AMA delegation, the quality of their performance, the force with which they represent our interests, and the attentiveness they give to their duties are highly significant. The House should carefully assess these factors.

As a means of helping the House to be as knowledgeable as possible in these and other matters, I have suggested that you set up a Interim Committee of your selection to serve between sessions. It would have a free-ranging mandate to bring to the succeeding session the reports and recommendations which the committee would develop from the particular perspective of members of the House of Delegates.

Finally, we should not forget that our profession is truly a vocation, a consecrated calling. We had our origin in the mists of antiquity, when the healer was indeed of the priesthood. The traditions and the ideals that have come to us over the centuries are a good and honorable heritage. Let us cherish them and observe them in the context of the final third of the twentieth century. Thank you.

Printed Report of the President

HOUSE ACTION: Approved with the recommendation that the president's recommendations be considered and implemented where possible by the Board of Trustees and/or appropriate committees or commissions.

The major objectives which I have sought were:

1. *Involvement of all eligible doctors in ISMA.* I have written to each non-member doctor in the state inviting him to affiliate with ISMA. There should be relevant activity for every segment of the profession, effective responsiveness to all of our members, projects which benefit the members and the public, and cooperation with other medical organizations with a joint annual meeting for all as an ultimate goal.

2. *Rapport with students and teachers of medicine.* We have made definite progress. One good project is a "retreat"-type meeting for students, faculty, and practicing physicians. Another is the participation of SAMA in as many phases of our activities as is practical.

3. *Dialogue with the public sector.* This has been cultivated at every opportunity. Particular care was devoted to liaison with all public officials at every level. The major effort was the appointment of an Advisory Committee on Health Care, made up of fellow Hoosiers. I will have a report to present to the House on this significant undertaking.

4. *Cooperation with hospitals and with third parties.* More understanding has been developing as a result of joint meetings devoted to candid, honest exposition of problems and differences. One big step was the meeting for chiefs of staff, administrators and hospital trustees sponsored by IHA and ISMA in September.

5. *Coping with the health manpower shortage.* This relates to continuing education and maintaining a contemporary professional posture, reassessment of our capabilities and our limitations, managing the paper load, and delineation of the roles of ancillary and allied health workers.

* * *

The first portion of the year's work was preempted by the session of the legislature. This required uncounted man hours of work by officers, the Commission on Legislation, staff and many members. The results from our standpoint were most satisfactory.

The Conference of Medical Society Officers in March was productive. Our new Commission on Emergency Medical Services has already accomplished a great deal. One result is the plan to erect a series of emergency medical highway signs as a pilot project. A course in sports health medicine was conducted early last month at the medical center sponsored by our new Committee on Sports and Medicine. An ad hoc committee reported to the Board on its evaluation of some problems in the Department of Mental Health; the findings were offered to the governor. A cooperative program among the directors of the Student Health Services of our major universities has been initiated. This

is only in its formative stages, but, in my opinion, has great merit and very real potential.

Innumerable achievements—some large, and many small—have been attained; much is routine, but it would be evident if it had not been unobtrusively done.

The Board of Trustees, commissions, and committees have worked diligently. Their reports, which you will receive, contain valuable data and many stimulating ideas for consideration.

RECOMMENDATIONS

The President's Page from *The ISMA Journal* for November, 1968 and for May, June, and July, 1969, are included as a part of this report. The recommendations therein are offered for your consideration. Some of the programs advocated are (a) Professional Standards Committees; (b) making local and district societies congruent with actual medical service areas in place of the present political geographic areas; (c) promoting cooperation among all medical professional organizations, particularly by coordinating staff work, sharing facilities, and integrating their annual meetings with ours; (d) reappraisal of relationships of fees and regular revisions as needed, and (e) dealing with the growing paper load.

I recommend the formation of a new Section of College Health Medicine.

The ever-increasing exposure of medical practice to legal hazards has an urgent priority. I believe the most practical measure to consider would be to adapt the concept of workmen's compensation benefits so as to apply comparably to mishaps occurring during medical care. I urge the House to authorize the Medical-Legal Review Committee and the Commission on Legislation to develop suitable measures to present to the Board of Trustees in preparation for the next session of the legislature.

I suggest that the House consider establishing a Committee on the Good of the Association. It would be elected by the House to serve during the interval between annual meetings and would report back to the House. It would have a mandate to observe, to study, and to investigate any phase of association activity which might attract its interest. Ideally, it should include no current officer. It would function in so-called Ombudsman fashion within wide ranging limits.

Many other suggestions which I endorse are embodied in reports from the commissions.

I thank the many members who have given suggestions, counsel, admonitions and assistance. I have invariably encountered gracious cooperation and heart-warming friendliness from all the membership. It has inspired me and sustained me. I am grateful to you for having entrusted the presidency to me. On the whole, it has truly been a happy experience. My best efforts will continue in the service of ISMA.

PATRICK J. V. CORCORAN, M.D.,
President

In Memoriam

Following is a list of members of the Indiana State Medical Association, notice of whose death has been received during the last year. The House stood in memory and tribute to the following.

CARYLE B. BOHNER, Husca, Mexico (formerly Indianapolis)
EDWARD W. CUSTER, South Bend
CLAUDE M. DONAHUE, Carmel
BERTRAM F. DUCKWALL, Terre Haute
WILLIAM S. EHRICH, Evansville
ALLAN K. HARCOURT, Indianapolis
BENJAMIN L. HARRISON, New Castle
LLOYD J. HOLLADAY, Lafayette
CARL M. HOSTETLER, Elkhart
WALTER F. KAMMER, Muncie
JOHN L. LANGOHR, Columbia City
J. KENT LEASURE, Indianapolis
ALBERT L. MARSHALL, Jr., Indianapolis
HENRY O. MERTZ, Indianapolis
MAHLON F. MILLER, Fort Wayne
THEODORE D. RHODES, Sarasota, Florida (formerly Indianapolis)
GERALD H. SOMERS, Fort Wayne
WALTER E. STEWART, Terre Haute
CHARLES E. STOUDER, Ellettsville
ALFRED A. THOMPSON, Tyner
WILLIAM R. TROUTWINE, Crown Point
HAWTHORNE C. WALLACE, Crawfordsville
ROBERT H. WISEHEART, Lebanon

Approval of Minutes

The proceedings of the 119th annual meeting of the House of Delegates held in Fort Wayne, Indiana and published in the January, 1969 *Journal of the Indiana State Medical Association* were approved upon motion duly made, seconded and carried.

Remarks of President Corcoran

Any delegate who introduces a resolution from the floor, providing two-thirds of the House approves of his resolution being introduced, shall first submit the resolution to Reference Committee No. 1 (Rules and Order of Business) to determine if the resolution is of such an emergency nature that it cannot be held over until the next meeting of the House. The proponents of the resolution, in addition to supplying 150 copies of the resolution, shall in writing set forth the reasons why this resolution was not made available to the delegates prior to coming to the House of Delegates meeting.

Reference Committee No. 1 is in session just outside the entrance to the Ballroom.

Appointment of Reference Committees

In accordance with the Bylaws, I have appointed reference committees and the names of the members of these committees were published in the September *Journal* and in the Handbook.

These reference committees are to serve during this annual convention only and should not be confused with the commissions or standing committees of this association.

To these reference committees will be referred all reports, resolutions and measures presented to the House of Delegates at this session, except such matters as properly come before the Board, and the recommendations of these committees shall be submitted at the final meeting of the House of Delegates at 9:00 a.m., Friday, October 17, for acceptance in the original or modified form, or for rejection. The Friday morning meeting will be held in the Ballroom, Columbia Club.

Each reference committee consists of five members, the first member named is chairman. Will committee members please stand as their names are called?

REFERENCE COMMITTEE NO. 1:

Lowell W. Painter, Winchester (Randolph), *Chairman*
Fred Carter, LaPorte (LaPorte)
Francis Gootee, Jasper (Dubois)
W. F. Kerrigan, Connersville (Fayette-Franklin)
Walfred A. Nelson, Gary (Lake)

REFERENCE COMMITTEE NO. 2:

A. Alan Fischer, Indianapolis (Marion), *Chairman*
William G. Bannon, Terre Haute (Vigo)
Truman E. Caylor, Bluffton (Wells)
Guy B. Ingwell, Knox (Starke)
Albert S. Ritz, Evansville (Vanderburgh)

REFERENCE COMMITTEE NO. 3:

Betty Dukes, Dugger (Sullivan), *Chairman*
Lloyd L. Hill, Peru (Miami)
James F. Peck, Princeton (Gibson)

Louis F. Sandock, South Bend (St. Joseph)

Charles E. Test, Indianapolis (Marion)

REFERENCE COMMITTEE NO. 4:

Robert Seibel, Nashville (Bartholomew-Brown), *Chairman*

Lester L. Renbarger, Marion (Grant)

Hugh K. Thatcher, Indianapolis (Marion)

T. C. Tyrrell, Calumet City, Ill. (Lake)

John D. Wilson, Evansville (Vanderburgh)

REFERENCE COMMITTEE NO. 5:

Fred Smith, Jr., Tell City (Perry), *Chairman*

Fred W. Dahling, New Haven (Allen)

Thomas A. Elliott, Elkhart (Elkhart)

Richard Ingram, Montpelier (Delaware-Blackford)

Howard R. Marvel, Lafayette (Tippecanoe)

Amendments to the Constitution

HOUSE ACTION: Adopted.

At the 1968 annual convention at Fort Wayne, the House of Delegates adopted the report of the Reference Committee on Amendments to the Constitution and By-laws, in which the Reference Committee recommended for adoption the following amendments to the Constitution:

Be it resolved that Article IV, Section 1 of the Constitution be amended so as to read:

"Section 1. This association shall consist of active members, associate members, senior members, honorary members and disabled members." (This merely adds a classification of disabled members to this section of the Constitution.)

Be it resolved that Article IV, Section 6 of the Constitution be amended to become Article IV, Section 7 and that a new Article IV, Section 6 be added to the Constitution to read as follows:

"Section 6. —Disabled Members. Disabled members shall consist of physicians of the state of Indiana who are certified by a member physician to be permanently disabled and no longer able to practice medicine and who continues to reside in the state of Indiana.

"Proof of permanent disability shall be by notification of the secretary of the association by the secretary of the county medical society in which such permanently disabled physician holds membership."

Be it resolved that a new subsection be added to Article IV, Section 7 of the Constitution to read as follows:

"e. All such disabled members, as defined above, shall receive association membership cards and *The Journal* of the association without charge."

Address of President-Elect Lowell H. Steen

HOUSE ACTION: The House considered the many possible recommendations of the president-elect but regrets that there is not proper procedure to begin immediate implementation. The House approved the establishment of a Reference Committee of the House for the sole purpose of studying the addresses of the president, president-elect, the report of the executive secretary and of the chairman of the Board of Trustees. The House also approved the establishment of a Youth Health program and referred this to the Board for implementation. The House also approved the study of a Medical Disciplinary Board and a proposed law for implementing such a law, with the recommendation that the law be brought back to the 1970 House of Delegates. The House also recommended that the Commission on Constitution and By-laws study the feasibility of establishing an interim session of the House of Delegates or an interim study committee and that their recommendations be reported to the 1970 House of Delegates.

It has been the custom of my illustrious predecessors to deliver to this House of Delegates a scholarly presentation—erudite, thought-provoking, and stimulating. I do not believe I could succeed in preparing a dissertation of sufficiently high caliber to have it remembered long, nor to permit it to make any impact upon the membership of this organization. I therefore propose to depart from this established tradition and reflect briefly upon what I have come to believe *can* be the role of this association and other allied organizations who are engaged in socio-political activity. I propose to outline to you three programs that, if effected, can assist in altering our image and can deprive our adversaries of some of the ammunition which has been used as the justification for the changes they clamor for. Time refers to the time in which we live—time of change. I shall expand at some length on the way we use our talents so as to effectively direct them toward delivering high quality medical care; and I shall last address myself to a plan for teaching the youth of Indiana, our heirs and citizens of the future, that physicians do have a vital interest in their present and future health.

The famous Danish philosopher and theologian, Soren Kiekegaard wrote, "To venture causes anxiety, but not to venture is to lose one's self." Our profession today finds itself buffeted by multifarious pressures—labor, industry, private insurance carriers, the government, and the poor, the blacks, ad infinitum. The pressures for change are overwhelming, and as the population grows numerically and has tasted the fruits of more and better medical care, these wants become less well satiated, and so an ever spiralling demand for more and more occurs. It has been imminently proven that what the public wants, the public gets. To deny that change has occurred and that change will occur in the future is to deny existence in 1969. Our posture in the past has been a negative one! There was a time in our sociological evolution that the economic environment was favorable to a negativistic approach to the demands of the public. Yet, with the administration of Lyndon B. Johnson and its passage of Medicare, it has been conclusively demonstrated that negativism will no longer work. We cannot permit the physician to be forced into the role of a technologist in his own profession. We must not be apologetic about the words profit and free enterprise which have come to represent undesirable concepts in the environs of the Potomac River. We cannot abandon the profit motive with its proven ability to provide a pathway to achievement, but we must assure against substandard quality, while at the same time we increase productivity to insure against the proposed substitutes. We cannot be forced into the role that we must work longer hours for less pay to solve the government's financial dilemmas. That technique is too readily apparent. Now that the public has sipped the nectar of what they have been promised, they yearn for more, but at the same time there are only so many health care dollars, and in order to save political face, the politicians must decree that it is the physician's blame for the failure of the programs that were designed without his advice or consultation. We must not permit the practice of medicine to be used as a cat's paw by those with ulterior motives who would make basic changes in the accepted fabric of our social and political structure; for slogans, and dollars, and laws, and regulations cannot provide medical care. It cannot be provided by those who are promising it. Health care can only be provided by physicians motivated by the desire to provide more and better care, which perforce will require new techniques, new approaches, and considerable alteration in

the accepted techniques by which we now provide this care. As unpalatable as this pill may be to those of a conservative persuasion, these programs must be consumer-oriented, they must be community based, and they must be incentive motivated and physician guided.

The public has been led to believe there is a crisis in the delivery of health care. Yet, the existence of this crisis did not originate with the public, but rather, the public is being convinced of its existence by certain highly placed and highly opinionated officials, both private and public. Nonetheless, we must accept that this alleged crisis has been used as an excuse for setting in motion trends now so irreversible that we can ask only for the wisdom to recognize them as such. And I cite here the much tarnished quote, "Oh God, grant us the serenity to accept what cannot be changed, the courage to change what can be changed, and the wisdom to know one from the other." Therefore, I would urge you that our role must be to innovate. Our role must be to seek new ways of providing the care that must be provided. Our role must be to protect and define our right to a reasonable profit for our productivity, yet carefully balancing this against our prejudices toward the traditional mode of the delivery of service. At the July meeting of the American Medical Association, the architect and planner of the future of medical care in this country, Mr. Wilbur Cohen, carefully and lucidly drew for the profession the blueprint. Let us take this blueprint and modify it to our liking. Let me hasten to add, I did not say sell out to Mr. Cohen; I said seek ways to deliver what is wanted in a fashion palatable to us. The famous virologist Rene DuBois, in his book published in 1965 entitled, "Man Adapting" says, "Medical science must reconsider some of the assumptions on which it decides the relative importance of various subjects and shift some of its emphasis from elementary units and reactions to the matter in which man responds to the threats he encounters in the world. To deal with these problems, medical institutions will have to escape from their bondage to a scientific tradition that has its origins in the 17th Century. They must forego the security of the future built on the logical outgrowth of the past, for the uncertainties of a future so willed that organismic and environmental medicine finally receive their share of attention. Such a course naturally entails intellectual discomforts and risks."

Therefore, I urge upon you unity in our attempt to influence the unchangeable. Because the makers and preservers of the American Republic were religious men, Mark 3:25 has been a text repetitive throughout our history—"If a house be divided against itself, that house cannot stand." And although George Washington in 1776 used this text as a ground for his argument for American independence; Abraham Lincoln drew upon the same text in Springfield, Illinois on June 16, 1858, as a support to political argument that the American house should not be divided. And although I have equal admiration for these two giants of American history, I must take Lincoln's thesis of the scriptural text for my argument that our profession cannot stand as we now know it—divided.

I am sure that every individual who soberly reflects upon the problems that face us can come forth with one or more programs that, when intricately fit together like a jigsaw puzzle, help to solve the problem. If one imagines each of the many involvements as pieces of a jigsaw puzzle, one can understand the importance of a multiple pronged approach. In my judgment, one area with which we must immediately concern ourselves is in peer review. Many people first hearing the term peer think immediately of the British system of peerage in which there are barons and viscounts and princes, yet, in the context that the term is used today, I take from Webster's Seventh Collegiate Dictionary the definition of peer—"One that is of equal standing with another: equal: companion, fellow." So, we speak of review of the physician's activities by his equal, and regardless of the skill or specialization of a physician, somewhere in the world exists a peer in that same field. For many reasons peer review is a valid activity for the profession. I cite many resolutions by the AMA, pressures by the public and by labor, and by insurance carriers for assuring the public of the quality of medical care. There is the threat of federal intervention through the use of state audits, and the urgent requests from the Health Insurance Council, Blue Cross Association, and National Association of Blue Shield Plans, to help administer programs on the basis of usual, customary, and reasonable fees. Most persuasive in my judgment is the desire of physicians to retain control in judging the quality of their own work, apart from the pressures of the same labor, management, state regulatory bodies, and the federal government. Physicians must respond to the pressures from private practice closed panel groups established at such places as Harvard, Yale, Johns Hopkins, and Washington University, who claim that they can provide care efficiently and economically because of the nature of their closed panel practice. This House of Delegates in 1956 passed Resolution 26, which one of our component societies wishes to rescind, yet inherent in this program that has expanded and is now widely sold throughout this state is the concept of fee review. Physicians have never feared the review of the quality of their clinical work in the hospital setting, nor should we now fear the review of our utilization, under-utilization, over-utilization, professional standards and ethics by our peers on a broader scale. We must not envision this as a police action. It can be an educational process, not only for those doing the reviewing, but for those being reviewed. Since more and more health care is being delivered on an outpatient basis, it is only a logical extension of our previous technique that we review what we do in our office as well as we review what we do on an inpatient basis. Through techniques of peer review, valuable source data can be obtained that can be used to refute the claims made by our adversaries who now collect and distort their own data to tout the value of the product they would foist upon us. Through peer review we can identify patterns of medical and hospital practice in the city, in the county, and in the state, and through this mechanism we can bridge the gap between the health insurance industry and the government by being responsible for setting the patterns, as well as adamently justifying the fees on a truly fair, reasonable and customary basis. And although peer review involves fee review, its most important application is in the realm of utilization. In our current milieu we must give consideration to medical necessity as well as to charges, services, length of stay, consultations, laboratory work and x-ray facilities. In our own state today there are ten review committees in existence. And I would hope that by October of 1970 there are review committees existent in every county or joint county society in which there are 20 or more members. I believe it unfair and patently difficult to ask a county or joint county society of 20 or less physicians to carry on this activity. I believe we need not set down strict criteria! I can envision some county societies where ten physicians work so amicably that peer review could work well, and I also recognize where ten people must work together closely, this could be a problem. Therefore, I have arbitrarily chosen the number 20. I urgently recommend that this House of Delegates give high priority endorsement to the concept of peer review, and that it strongly urge all county societies to establish review committees. I request endorsement for the establishment of a State Peer Review Committee, and I propose that the chair-

men of the ten existing review committees compose this committee. I would hope that this committee comes forth with recommendations as to how to proceed with peer review and that it will serve as a reservoir of expertise in the area. I would hope that we are sufficiently sophisticated so that in areas where the number of physicians is too small to carry on this activity, that they will be willing to delegate this function to the state review committee, and I would further hope that this committee could become the review committee for the OCHAMPUS program now administered by your state medical association. My dedication to this activity is founded on long experience and service on a review committee in my own county medical society where I have served continuously since its establishment 13 years ago. I must impress upon you that review is not synonymous with lowering fees. I believe we must fairly recommend escalation when escalation is warranted. Yet, we with equal vigor must resist obvious overcharging and overutilization. We can monitor our costs throughout the state and throughout the nation by a friendly, understanding consideration of the quantity and quality of care delivered at the usual, customary and reasonable price. If we widely publicize these facts to the public and to the purchaser of health care, we will have driven a large and important wedge in the arguments used against us today. Therefore, I again recommend approval of the concept of peer review and the endorsement of this House of Delegates to stimulate its implementation on a statewide basis.

One of the criticisms leveled against our profession repeatedly is that although we police ourselves, we do not have an effective mechanism for enforcing the discipline we espouse. As a corollary to peer review there are some several tangential considerations—namely, discipline, ethics, competency, and outright fraud. Again, we deal with an infinitesimal percentage of physicians, yet it is a percentage that attracts widespread attention and brings dishonor to a time honored profession. Our State Board of Medical Registration and Examination is the legally constituted body whose purpose is to determine one's qualification for the practice of medicine and to grant that privilege. When a body is legally constituted to grant a privilege, they must be granted the power to revoke that privilege. It is my opinion that if the disciplinary powers were vested in a Medical Disciplinary Board separate and apart from the Board of Medical Registration and Examination, we could more effectively accomplish both goals; for the direction of each could be properly oriented toward their individual purpose. These purposes need not necessarily be in opposition, for I envision them as a complementary activity. You may ask why we need an additional board. I believe there are several impelling arguments in its favor. First of all, as a medical association, or as a county medical society, the only technique we have to exert influence on that small minority of recalcitrants is by censure or suspending the physician's membership, or by placing him in a probationary status, during which time he comes under the survey of an appointed peer preceptor. Currently in this state, a physician unfit to practice medicine cannot be deprived of that privilege unless he has been convicted of a felony, or has been convicted of narcotic addiction, or unless it has been proven that he has engaged in gross immorality in the practice of medicine, whatever that is. When we have a poor, unfortunate physician who suffers from some mental aberration, or who becomes overtly mentally ill, and if he then conducts himself in an unbecoming manner, it is the entire community of physicians who are blamed. Yet we have no effective technique by which we can solve his problem. I have personally observed several senile physicians who, for their own safety and the safety of their patients, should not have practiced medicine. Yet, even though their hospital privileges were drastically curtailed, they could blissfully work in the sanctity of their own office day in and day out. Cases of pure fraud go unchecked for lack of a legal mechanism to combat them.

I believe the time has come that Indiana must have a medical disciplinary board. I believe this board should be legally constituted by an act of the legislature. I believe this board should be composed of physicians elected by physicians. I believe this board must be delegated broad discretionary powers, and I believe we, as physicians, have a responsibility to make certain that we have a technique that is effectual to control our physicians who do not purport themselves according to the high standards that the vast majority follows. I would suggest that this board be composed of 11 physicians—one from each existing congressional district; that only M.D.'s holding an unlimited license to practice medicine be permitted to serve on the board; and that they be nominated by petition of ten or more physicians. I propose that a mechanism be set up so that only those physicians practicing in the congressional district in which the nominee resides can vote for the member of the board from that district. I propose that they be paid a stipend sufficiently great to cover the time spent in their deliberations, but that the stipend not be so large that it becomes attractive financially to serve on the board. This board should have permanently assigned legal counsel from the Attorney General's office. It should have the power to subpoena witnesses. It should have the power to not only recommend suspension or revocation of a license which would be mandatory upon the Board of Medical Registration and Examination, but it should have the power to recommend commitment to a psychiatric institution, or to require that the individual alleged to have severe emotional problems submit himself to appropriate private treatment and show evidence thereof. It should have the power to remand the case to the appropriate civil court if such is indicated. Boards structured along these lines are now in existence in several states, the most notable of which is the state of Washington. I have in my possession all of the information relating to the operation of the Washington board. If this were in existence we would have a demonstrable technique for solving many of the problems that are now insoluble. We would again deprive our adversaries of one of the weapons of their armamentarium. And although the board might not be called upon to take action for several years, it would serve as a potent deterrent to that small minority who otherwise might go unchecked.

Therefore, I recommend that this House approve the principle of a disciplinary board and that it mandate the Board of Trustees or other appropriate commission of this association to study the matter in all of its aspects and ramifications, and that, further, it give the full support of the association to the preparation of an appropriate bill to be introduced to the next session of the legislature, establishing such a board. It is inherent in this recommendation that we use all of the forces at our command to influence our friends in allied professions to ensure the enactment of this legislation and to stimulate similar activity on the part of allied professions where applicable.

Finally, I should like to speak of our role as teachers. I want to discuss with you something that is very dear to my heart. I want to discuss with you something that is going to require the expenditure of a considerable sum of money, and a program that will involve other organizations and other people unrelated to the field of health care. Our president has spoken eloquently on many occasions of the duties of a state medical association, and about our responsibilities not only

to ourselves, but to the public and to our professional heirs. I would suggest that as physicians we have a professional responsibility and a civic responsibility to the youth of this state, and it is about the youth that I am thinking in the project that I am about to present to you. In January of this year I presented this program to the Board of Trustees who approved it in principle. At the March meeting of the Board, they reaffirmed their dedication to the project and an ad hoc committee was established. This committee has met on several occasions. Progress has been made. We have already enlisted the support of a number of allied organizations, and the president of the Woman's Auxiliary, Mrs. Schneider, has met with us as a member of the ad hoc committee and has attested to the validity of the program by her vigorous involvement, not only personally, but by stimulating your wives to involve themselves in the program. I will tell you later of Blue Shield's commitment to the program. I stole this idea in toto from the Wisconsin State Medical Association, and as I said previously, I am enthusiastic about this program. I urgently recommend that this House of Delegates approve the establishment of a Youth Health Program. This program should be held in the spring of the year, and every high school student in Indiana should be invited to attend. This should be a program sponsored by the Indiana State Medical Association and should be run by it. We should devote not only our talents and time, but a significant sum of money to the program. I propose that we invite these students to Indianapolis for a two-day period, during which time they will be housed at their own but at a minimal expense at the State Fairgrounds where the program will be conducted. We should discuss with them every aspect of human life and interpersonal relationships of human behaviour. We should discuss with these students venereal disease, sex, drugs, operation of automobiles, alcohol, smoking, what to do in the case of an emergency, hygienic living, and any other topic that may be of short-term or long-term importance to a teenager. We should obtain the services of renowned experts from throughout the country as speakers. We should make use of the voluminous talent repository in this organization. We should involve the Indiana State Police and the Indiana Dental Association, sociologists, psychologists, educators, staff from the State Board of Health, and many other organizations. I propose that these talks and panels and discussion forums should be video-taped so that they can later be used in toto or in segments to present programs at high school assemblies, and that they can be aired on local radio and television stations throughout the state. The Blue Shield Board of Directors has already given approval to appropriating sufficient funds to accomplish this latter recommendation. When this was done in Wisconsin, the video and audio tapes were used over a thousand times on radio and television stations throughout the state. I think it is immediately obvious to you the public relations value that this program can have to the Indiana State Medical Association and to us as individual physicians. I have spoken to a number of teenagers who are very enthusiastic about this program and believe that it will have widespread appeal. I believe this is a non-controversial, educational function of this organization that can be widely supported by those of all political persuasions, and as I have studied the possibility for over a year, I cannot think of anything but good that can come from our involvement in a program of this nature. I therefore with great enthusiasm recommend that the House of Delegates concur with the recommendation of the Board of Trustees and mandate the Board and its subcommittee to establish this as a prime program of the Indiana State Medical Association for the year 1970. I would hope that after one year's experience with the program that at the meeting of the House in 1970 its impact would be reviewed so that if it has the value I believe it will have, it be made a permanent program of the Indiana State Medical Association. I, personally, cannot conceive of a better way to spend some of our money than on the youth of this state, nor can I conceive of a better way of improving our image, or of communicating with a significant segment of the population with whom communication has been difficult.

I know each physician in this association is dedicated to the care of his patients. I further know that we are all dedicated to our chosen profession. It is regrettable that communication has become the problem it has. We converse much, yet we sometimes fail to communicate. So with each physician doing his part each day, and with the collective force of over 4,000 physicians in this state exerting our influence in a cohesive fashion, we can use our time and our talents and teach the public that although we live well, we do work hard and do have the best interests of the public foremost in our consideration. Or, as the poet Henry Van Dyke so eloquently said,

"Let me but do my work from day to day,
In field or forest, at the desk or loom,
In roaring market place or tranquil room;
Let me but find it in my heart to say,
When vagrant wishes beckon me astray,
'This is my work; my blessing, not my doom;
Of all who live, I am the one by whom
This work can best be done in the right way.'"

Printed Report of the President-Elect

The Indiana State Medical Association is one of the most active and viable state medical associations in the nation. Our influence on the affairs of the AMA is disproportionate to our number. Much of the credit is due the elected and appointed officials from Indiana who serve in the AMA. One cannot attend a meeting of the AMA without being impressed by the very significant impact that our executive secretary, Mr. James A. Waggener, has in translating our policies into effective action. I never cease to be amazed by his ability to accomplish what appears to be the impossible. We should all be aware of his value to ISMA and I personally thank him and his staff for the outstanding job they do.

In my opinion, there are five major challenges that face medicine today. In the past three years I have spoken of these five challenges on many occasions and my thoughts are a matter of record in the minutes of the Board of Trustees. I feel so strongly about these areas that it warrants calling their attention to the House of Delegates. Hopefully, these topics will provoke discussion in reference committees where they are cogent. In addressing himself to the problems confronting his administration as president of the AMA, Dr. Gerald D. Dorman of New York has outlined some of the same points that I consider overwhelmingly important.

Continuing Medical Education. We must involve ourselves more vigorously in continuing medical education. The Commission on Medical Education has been charged with the responsibility to develop a number of programs and they have started. However, they cannot by themselves accomplish this without the cooperation of every county medical society in Indiana. It is imperative that we seek new ways to make programs available so that they are painless pills for the practicing physician. The "throw-away" literature is flooded with articles urging physicians to learn and pointing out how learning can be fun. Our school of medicine has pledged their cooperation in developing new techniques by which learning can be more painless and by which physicians can improve their skills and basic working knowl-

edge. I, therefore, recommend that this House of Delegates require each county society to show evidence at the next meeting of the House of their attempts to organize programs in continuing medical education. I further recommend that the Commission on Medical Education be instructed to develop a curriculum of the programs now available in Indiana and that the curriculum be kept current.

Health Manpower. The executive secretary has beautifully pointed out the problem of the physician shortage in Indiana. This has been repeatedly stressed for a number of years. Much conversation has been devoted to the techniques of obtaining more practicing physicians for Indiana, yet the yield continues to be painfully low. I think it is the responsibility of the Indiana State Medical Association to search for ways to retain physicians in Indiana by whatever means is necessary. The governor's recently appointed commission to study medical education may outline some techniques that will increase the output of physicians, but I am certain that merely increasing the output will not solve the problem. I do not have the answer to this serious dilemma, but there are many brilliant minds seated in this House of Delegates who, in concert, may conceivably find that solution. I therefore recommend that an ad hoc committee of the House of Delegates be appointed to consider the problem of health manpower. This committee should be mandated to report their deliberations to the next session of this House.

Emergency Medical Service. Our state medical association has been active in this field for at least two years. Several of our component county societies have led the way in cataloguing in compendious form a plan for emergency service in their areas. The Fort Wayne Medical Society is to be commended for their leadership in this field. A statewide approach to the problem must move forward rapidly in order to assure the delivery of emergency service of an extremely high quality in every area in the state. The classification and accreditation of emergency facilities must come. Ambulance standards must be implemented. Training of ambulance attendants must perforce come. The entire gamut of emergency medical service has been carefully studied by our Commission on Emergency Medical Services. Emergency service is of vital concern to all physicians in Indiana and ISMA must exert its force, translating plans into action. I recommend that this House of Delegates urge the Commission on Emergency Medical Services to move forward with all practical haste to implement the utopian goals they have set out for ISMA.

Two other critical and important areas of activity I will deal with in my address to the House.

It has been my pleasure during my term as president-elect to attend the meetings of several other state medical associations. It is a rewarding experience to learn the problems of neighboring states and how they solve them. In so doing, I have noted certain valuable techniques that I should like to recommend to the House of Delegates, which may facilitate the work of the House and make the decisions of the House more understandable to the membership.

Reports of Board of Trustees. In the past, the policy decisions of the Board of Trustees, which must be acted upon by this House to become state medical association policy, have filtered through either in the form of recommendations in the report of the chairman of the Board, or in the form of formal resolutions. Often gray areas exist in which matters are referred to the Board and policy decisions are made, yet these continue to abide in a hazy, distant, and nebulous form so that the House of Delegates is never fully cognizant of these decisions. Therefore, I propose that in the future, all policy decisions made by the Board of Trustees be reported to the House in the form of a report compiled by the executive secretary, or by a committee of the Board, or by the chairman of the Board himself, or by whatever technique the Board may elect to use for preparing these reports. I further recommend that these reports be forwarded to the House for official action and be assigned an alphabetical cipher, i.e., A, B, C, etc. I further recommend that in the future the reports of commissions relative to matters of policy likewise be forwarded to the House in this form and under the style noted above.

Meetings of the House of Delegates. The vast amount of decision making required by a state medical association today is staggering. It is incomprehensible that even the carefully selected delegates to this House should be expected to digest and solve the multiple problems presented to it in one short session each year. I believe many more people would be involved in decision making and that the deliberations would be more meaningful if the House of Delegates would structure an interim session, perhaps a two day meeting about five or six months after the annual meeting in October. I do not believe there should be scientific presentations, nor should there be exhibits. It is my recommendation that the House establish an interim session, the details to be worked out by the Reference Committee, and by the Commission on Constitution and Bylaws.

Reference Committee on the Reports and Addresses of Officers. Some of what I have said about policy decisions by the Board of Trustees applies to the recommendations made by officers. In observing the implementation of the recommendations of past presidents, and of past presidents-elect, I note that in many instances valuable suggestions have been made but have never been translated into activity. This, I believe, is the result of the patronizingly polite way the Reference Committee usually commends the remarks of those officers and commends them to the House. The House approves the report of the Reference Committee, and through no fault of any individual or group of individuals, the matter there rests as a recorded monument to the wisdom of an individual without ever being translated into action. Therefore, I recommend that appropriate changes be made in the Constitution and Bylaws to require that one Reference Committee be set aside for the sole purpose of studying the addresses of the president, president-elect, the report of the executive secretary and of the chairman of the Board of Trustees for significant recommendations. I further suggest that this committee be mandated to translate these recommendations into resolutions to be presented to the House. Widespread discussion in the Reference Committee is then possible before they are subsequently acted upon officially by the House. By this procedure there will be clear-cut definition of whether or no the House wishes to implement the recommendations of these officers.

LOWELL H. STEEN, M.D.,
President-Elect

Remarks of Mrs. Kenneth Schneider, President of the Woman's Auxiliary to the Indiana State Medical Association

HOUSE ACTION: Accepted for information.

Distinguished guests, and members of the House of Delegates, you are the most handsome captive audience I've ever had the pleasure of addressing. This month is the half-way mark in my term as president of the Woman's Auxiliary of the Indiana State Medical Association. The past six months have been hectic, frustrating, interesting, rewarding, nerve-wracking, time-consuming, and enjoyable, and thank you

for letting me share these emotions with you.

Unless you think me all emotion, let me tell you of some of our activities, the achievements made since our last auxiliary report and our plans for the final part of this fiscal year.

One of the most pleasurable experiences I had was attending the AMA Convention as the Indiana state presidential delegate. How great it is to be from Indiana when members of our auxiliary receive so much recognition! You may have read that Ethel Gastineau was awarded an honorary membership and another past state president Yi Kintner was elected to the nominating committee.

We have a splendid group of state officers and chairmen who were willing to meet during the summer and organize the area workshops held in September—one in Evansville, one in Indianapolis, and the other in Fort Wayne. Great needs still exist for the type of experience and exchange of ideas gained in these meetings, and state leaders continue to look upon them as necessities in the list of important services furnished by them to the county auxiliaries.

Our fiscal year closed in April with the annual House of Delegates held in Fort Wayne. At that time our total membership was 2,853, a very slight increase over the previous year. These figures represent 52 active county auxiliaries consisting of 2,775 members. The remaining 98 are members at large. We are operating on a budget of $7,208.

This year the record-breaking sum of $428,875 was raised by the Woman's Auxiliary to the AMA for the AMA Education and Research Foundation. Reaffirming our interest in the future of medicine, Indiana's contribution to the total was $17,721. Funds for medical schools, the Loan Guaranteed Fund, and the Biomedical Institute are the three phases of the foundation which receive our support.

Community service activities total more than 50,000 hours of volunteer work in the 15 counties where estimates of the time involved were tentatively reported. However, Indiana can doubtless claim at least three times that number of hours. Auxiliaries cooperate with all phases of service work in their communities and actively carry on programs in mental health, safety disaster preparedness, and international health activities. Meals for home-bound programs are especially successful in Evansville and Elkhart auxiliaries. Health career programs do a remarkable job in interesting young people in choosing work in the health field. Working closely with Indiana Health Careers, Inc., auxiliaries have programs of far-reaching effect as they set up health career days, sponsor future nurses' clubs, and candy-stripers.

Loans and scholarships totaling about $15,000 were granted qualified young people working in paramedical fields of training. But I think we have only scratched the surface. I have just returned from Chicago where I attended the president and president-elect's fall conference. And I returned home wondering if we in the health field are doing enough to help solve the health manpower shortage. I think not.

Next week I shall begin a series of visits to county auxiliaries all over the state. The question I will pose to each county auxiliary and will recommend is that they expand their recruitment efforts beyond the health career days which are essential. We need to carry the health manpower message to all . . . to students on every level, to parents, to school personnel, to communities with their service clubs, and other organizations, and to the public. In this endeavor our standards should be high and strivings to attain them should be strong. The wives of physicians in Indiana have a golden opportunity to take action in the field of health careers. Our purpose is to help provide health services by recruiting more health workers. If we accept this responsibility there will be neither the time nor the necessity to worry about our public image. And when the laymen read articles like the one in a recent woman's magazine called "Never Marry a Doctor" they will say that description does not fit the doctors' wives that I know. *Our Hoosier Doctor's Wife* continues to be published four times a year, and is a most valuable channel of communication. We salute editor Jean Green who does such a fine job and also contributes to the national publication *M.D.'s Wife.*

The Woman's Auxiliary for the Student American Medical Association, SAMA, is growing by leaps and bounds, and continues to carry on worthwhile and stimulating projects. Among them are volunteer work at Riley Hospital, donations to the Marion County Welfare Department for special assistance to deserving families, and purchase of medical supplies for the Medical Clinic which SAMA is operating voluntarily in Indianapolis for needy families.

October has been designated as membership month by the Woman's Auxiliary to the AMA. Much emphasis will be placed on membership in Indiana this month and those to follow.

It is my pleasure to close this report by saying, "Thank you" to Dr. Corcoran, Dr. Everly, the advisory council, and Jim Waggener and the ISMA staff for their ever-ready cooperation and guidance. We in auxiliary feel we are fortunate in the single simple bond which ties us together so completely, as in no other group to which we belong. We are the wives of physicians; we measure our strength by this unity of purpose and by the effectiveness of our partnership with the medical profession. We are working to aid you, to justify the long-time designation of the woman's auxiliary as your most valuable ally.

Remarks of the President of the Indiana Chapter, Student American Medical Association

HOUSE ACTION: Accepted for information.

Mr. President, members of the Board of Trustees, members of the House of Delegates, and honored guests. I am pleased to have the opportunity of addressing you.

My address will consist of basically three phases. 1. Trying to briefly give you some insight into what national SAMA is trying to accomplish and has been accomplishing in the last year. The second part will give you a more or less run-down of what the local SAMA chapter of Indiana University accomplished last year, and the third part is what we plan to accomplish and how we feel we, as future physicians, may be able to work better and closer with the practicing physicians in the state of Indiana.

As you may or may not know, SAMA has undergone a fantastic change in the last two years. For some reason, and the reason is not entirely clear to me, medical students have finally become concerned about the problems of medicine . . . the problems which they will inherit in a few years after their graduation and postgraduate training. Because of this concern, many new programs have been initiated at the national level.

The first of these was the pilot project of a community health center in Kansas City, Missouri. This pilot project was funded by an AMA grant to get it off the ground. Last summer, 100 medical students spent time in another project in Appalachia, eastern Kentucky, West Virginia, and in Tennessee. This project was to expose students from all the different medical schools to the problems of the delivery of health care in a rural setting and in the worst possible type of rural setting. I am pleased to say that three members from the Indiana University Medical School were among those hundred.

Another priority of national SAMA is that of medical education, its evaluation and its relevance to the practice of medicine in our generation. Last year, the first annual convention of medical education of SAMA was held just prior to the AMA's convention in Chicago in February. Sixteen schools were represented by students and ideas and problems were exchanged.

The other priority of national SAMA is international health. SAMA has established liaison with student medical associations from foreign countries to establish an exchange externship program. Last year was the first year and 210 members of SAMA were exchanged with foreign medical students. Basically, the approach of national SAMA has been to try to evaluate problems that have been facing medicine and will be facing future physicians, like myself, and to try to make some sense out of them for its membership. Here at Indiana University the local chapter has also taken somewhat the same lead.

As you were informed last year by our past-president, Robert Forste, the students were then contemplating forming and initiating a clinic for the indigent people of the near southside of Indianapolis. I am pleased to say that on January 29th of 1969 this clinic was opened. It is staffed by medical students under the supervision of licensed physicians who volunteer their time. Also registered nurses and registered medical technologists donate their time to this clinic. We are open twelve hours a week, 6:00 to 10:00 at night, three nights a week. We have been seeing, on the average, approximately 90 patients a week, or 30 per four-hour session.

We've seen almost a whole gamut of what would probably be seen in a general practitioner's office—in fact, this is what we more or less envision ourselves as being —a general practitioner's office. We have established referral mechanisms with General Hospital and with Methodist Hospital to refer any cases that cannot be handled quickly on an outpatient basis. We charge 50¢ a visit to all these people who come to our clinic. We fill prescriptions; 99% are filled at no cost, primarily because 20 pharmaceutical industries or companies have given us over $20,000 worth of drugs. We pass these on to our patients. We have registered pharmacists administering our drug supply.

We have just gone through a summer in which there has been a transition. Of necessity, medical students, hopefully, only stay for a year and we will have a graduating class and a new class coming in. Last year was our first transition period and we have gone through this very well. This will be a continuing problem of continuity with our program; but we are pleased and we think that by involving all four classes, which we have done from the onset, we can minimize the problem of continuity.

I should say that our clinic is governed by a board of directors, 15 members in all. Four of these members are medical students, one is a staff physician at the university, and the other ten are community members, members who live within the geographical bounds of what we consider our community. These are the indigent. This board is empowered with setting policies for our clinic, primarily nonmedical policies. The medical policy as far as treatment, etc., of course, is left within the hands of the physicians and the people that they are supervising. Other questions, such as the time we should be open, and this and that, are left to this board to completely govern.

The other programs of local SAMA are very significant too because they have shown that we are very interested in working with the state medical association. The state medical association last year so graciously allowed us to use their facilities, their headquarters, for our monthly meetings, which we appreciated. We also have members on almost all of the commissions of the Indiana State Medical Association. These appointments, although we realize we can contribute very little at the onset, make a large contribution to our knowledge and to our education of the mechanisms and the means by which organized medicine approaches their problems and achieves their goals.

We hope in the future, in the next years, that we will be able to continue these programs. We have been continuing our program of holding meetings at the state medical association headquarters.

In September, five physicians conducted a panel on "Medicine, 1969, Where Are We Going" which was very informative. We are primarily concerned in these meetings with the social aspects of medicine and the social problems which rear their heads so largely to all of us.

In the future, what does SAMA have in store? Well, of course, our clinic is one of our major projects to which we are devoting a major portion of our effort. As I said, we are very interested in continuing our relationship through the commissions of the state medical association through meeting and interchanges with physicians.

We were very pleased with the retreat in September of members of the Indiana State Medical Association, students, and of the faculty of the medical center, at French Lick. We think these types of things are very important and very worthwhile so that ideas and problems may be exchanged.

You know it is very easy for students to be critical of their parents, of the physicians who are practicing, because we are not really involved in the problem; and I think one of the things we need is to become aware of the problems that physicians face, not only so that we will be more knowledgeable and less critical in many instances, but also we will understand the problems when we ourselves have to face them on a day-to-day basis.

This year for the first time we have an exhibit at this convention. We urge all of you to come and see it and talk to us. Students will be manning it almost all of the time that it will be open. We have a short eight-minute film concerning the clinic that may be of interest to you.

Also, and probably one of the most important things I can say, is concerning Resolution 69-22, which was submitted by the Board of Trustees. This resolution asks for your indulgenec and your knowledge in considering us, the students of the Student American Medical Association, and giving us a voice, a place in this House of Delegates in the future. You may think this is presumptuous of a student to ask for this, but I think not. I think there are several good reasons why it is very important that students be included and have a voice in your organization.

First of all, and probably the most obvious, is that we will be physicians in the very near future, and this will just give us a little added head start on the business and the problems of organized medicine.

Number two is that things that are decided today and tomorrow and this week by your association and by your House of Delegates will of necessity affect us in the future. It will affect the way we practice medicine and our relationship with society. We feel we should at least be given a forum, a place, to voice our approval or our disapproval.

Also, I think it is very important and probably rather obvious for our education to understand how much hard work is involved in organized medicine so that we won't be as critical of physicians as many members have been in the past, unfortunately. I think this is probably the most important byproduct of the whole gamut —our education—so that we can understand the problems the physicians face and the problems that we will be facing.

In closing, I urge you gentlemen to consider this resolution very carefully and to view it from a standpoint of the future physicians of Indiana joining the present physicians of Indiana in trying to solve

some of the problems of medicine and of the state of Indiana in deliverance of health care. Thank you.

Report of Chairman of the Blue Shield Board of Directors

HOUSE ACTION: Accepted for information.

DR. RYAN: Dr. Corcoran, Dr. Steen, officers, and members of the House of Delegates. It is a pleasure for me to report from the Board of Directors of Blue Shield. In your packet you will find a colorful report which I would like to urge you to look over at your leisure. I am sure it will not be necessary for me to read it.

You have all heard of the Blue Shield computer confusion which started back about last June. It got to the place where it couldn't even get out the current claims, let alone the old claims. About August 15, just to review, a new system was devised at which time the backlog was about $4,995,000. With this new system they were able to write the current claims but didn't get much done about the old backlog. On September 20 the backlog was $4,250,000 and at this time an unbelievable two weeks of claims processing was begun. By the eighth of October close to $7,000,000 in claims had been paid. These included the backlog and also included the current claims.

As of last Wednesday, October 8, a letter was mailed to each of you and to each doctor in the state of Indiana making a statement that the backlog had been cleaned up. Now it failed in this letter to state there were somewhere around 2,000 claims, not exactly lost, but just someplace around the office, that needed to be cleared up yet. We didn't want to give you the impression that some of you might have one or two claims that you might wonder about, but if you will follow the directions given in the letter about the inquiry regarding these claims and also how to file a duplicate claim, I am sure that it will all be handled in a very short time.

Blue Shield is most appreciative of the cooperation that the doctors of the state of Indiana have given them during this very trying time. Blue Shield has no intention of getting themselves in this predicament again and maybe it will be a better Blue Shield for having had this experience.

It has been a pleasure for me to report to you.

Introduction of Guests

The president introduced Rev. and Mrs. Joseph A. Steen, Delavan, Wisconsin, parents of Dr. Lowell Steen; Dr. Robert Mason, Birmingham, Mich., president of the Michigan State Medical Association; Timothy Norbeck, AMA field representative; Mrs. Patrick J. V. Corcoran, his wife; Shideler Harpe, of the Chicago office of the AMA, and Dr. Walter C. Bornemeier, Chicago, president-elect of the American Medical Association. They stood for recognition by the House.

Remarks of Walter C. Bornemeier, M.D.

HOUSE ACTION: Accepted for information.

Thank you, gentlemen. Ladies and gentlemen. It is a pleasure to be here. Naturally I bring you greetings again from the American Medical Association and from my own state of Illinois. The problems that you have before you at your session are similar to the problems that we have before us in Illinois and also similar to the problems that we have in the House of Delegates of the American Medical Association, so I will not presume to discuss problems because you are going to have them to decide and I don't want to get into the midst of an argument or try to influence anyone one way or another, except in the matter of the medical service to people in the ghettos.

I think the ghettos and the rural areas—I believe you people are sufficiently expert in rural areas and how to get medical service to them. I know that your university work on the preceptorship principle and that you are involved in that. I believe that all of us, and that includes us in Illinois too, our Chicago Medical Society is getting involved in the health care of the ghetto.

We have in Chicago one health center that is run by Presbyterian St. Luke's Hospital, called the Mile-Square Center. In that center we try to involve the entire family; they have a physician who is a doctor for the family; a social worker; and when they have outreached people whom they have treated who live in the area—they go out and knock on doors and go down the line to be sure that people have medical care. People in the ghetto don't know how to get medical care; it could be almost next door to them and they just don't go for it when they need it, even though they need it, they somehow are afraid.

We have for years said that we will take care of the poor but the poor haven't come a lot of times when they have needed service. So we need to use different methods. There is another health center in Chicago and there is one that is being developed that is funded by the medical school.

I think that all the methods, particularly the county medical societies, that is in the big city, can create a foundation—you can get funds from the federal government. You have to have it in order to build a facility because you can't set up a single office and expect a fellow to come down there and work even full-time or part-time because sometimes it is a rather dangerous area to work. But if you can set up a large enough facility where you have every service covered and if you've got good parking, with a guard on the lot, protected so you can leave your automobiles so that the things that are in your car will be protected, then I'll go down there and I'll give a half a week—come in from the suburbs—I no longer live in the suburbs but I believe that we'll have to come in from the suburbs to take care of them.

I think that we have to be innovative, try every type of plan that we can think of and in talking about innovation, I am always reminded of the story of the Texan who went up into Alaska to hunt Kodiac bear. He arrived and decided that he would go to a near sporting goods store to buy himself a gun and they told him he needed two guns, he needed trappings; he should take two guides with him and get in a plane and go out.

So all of this he did and they arrived out there and hiked in about ten miles, got to this cabin and the guides cooked dinner. The next morning while the guides were washing the dishes after breakfast, the Texan took off and was about a quarter of a mile out, going up over a knoll when they noticed him and they called to him, "Hey, you'd better come back here. There's bear up there!" He said, "Oh, I'll be all right."

And in about three minutes they heard him scream and come over the hill, "Open the door, open the door," and he was comin' and about fifteen paces behind him was a Kodiac bear. Gradually the bear was catching up to him but just as he got down to the cabin, with the door wide open, he stepped to the side, the bear goes in, he pushes the door shut and he says, "O.K. you guys, skin that one and I'll go get me another one!" Now that is what I call innovation and that's what you have to do in developing a center. Thanks at lot.

Presentation of Plaques

The president at this time presented on behalf of the American Medical Association plaques recognizing the humanitarian service of volunteer physicians in Vietnam. Presentations were made to Drs. Paul Waitt, Noblesville; Jack Shonkwiler, Greencastle and Donald Kerner, Indianapolis.

Election of Officers

OFFICERS: Dr. Malcolm O. Scamahorn, Pittsboro, was elected president-elect to succeed Dr. Lowell H. Steen, Hammond.

Dr. Lester H. Hoyt, Indianapolis, was re-elected treasurer by acclamation.

Dr. Hugh K. Thatcher, Jr., of Indianapolis, was elected assistant treasurer.

Elected chairman of the Board of Trustees was Dr. Peter R. Petrich, Attica. New Executive Committee chairman is Dr. Donald M. Kerr, Bedford. Re-elected to the Executive Committee was Dr. Burton E. Kintner, Elkhart.

ELECTION OF TRUSTEES: The only new trustee elected at the convention was Dr. Richard Ingram, Montpelier, Eighth District. Re-elected trustees were: Drs. Joe Dukes, Dugger, Second District; Wilbert McIntosh, Riley, Fifth District; and Lowell Hillis, Eleventh District.

Newly-elected alternate trustee was Dr. Thomas C. Tyrrell, Calumet City, Ill., Tenth District. Dr. John O. Butler, Indianapolis, was re-elected alternate trustee from the Seventh District.

AMA DELEGATES AND ALTERNATE DELEGATES: The following were elected to a two-year term as delegate and alternate delegate to the American Medical Association, their terms to expire December 31, 1971:

Delegate Dr. John Farquhar, Fort Wayne; alternate Dr. Patrick J. V. Corcoran, Evansville.

Delegate Dr. Jack E. Shields, Brownstown; alternate Dr. Thomas C. Tyrrell, Calumet City, Ill.

Reports of Officers

Executive Secretary

HOUSE ACTION: The House recommended that the problems of paramedical personnel be referred to the Board of Trustees for consideration and accepted the report for information.

Gentlemen:

In submitting an annual report it is always somewhat difficult since the affairs of the association extend in many directions; involving the Executive Committee, the Board of Trustees, the commissions, the various subcommittees of these official bodies and the staff.

Throughout recent years of activity the major emphasis of the association, it would appear, has been in the areas of legislation, medical licensure and medical education and socio-economic-political affairs, which deal directly with the profession in Indiana, and especially with the individual physician, as these matters affect his individual practice. Included has been a continuing concern with Medicare, Medicaid and health insurance. We feel that these activities are important, will continue to be so, and will need constant surveillance by the profession.

In my report to the association this year, however, I would like to place emphasis upon the activities of the association's various commissions, which have dealt with problems, in some instances not directly related to the individual physician's practice, but which are directly related to the health problems and needs of Indiana and your patients. In addition, I would like to report some of the innovative and imaginative programs which are under study by the commissions, and which in many instances are concerned with the individual physician's practice as well as patient care. With this brief preamble I submit to you in brief form singular highlights of each commission's total activity which must in the final analysis reflect upon the public relations and image of your association.

Scheduled appearances throughout the state before local groups such as Kiwanians, Elks Clubs, Rotarians, church groups, and professional organizations by the president of the association is being recommended by the Commission on Public Information. Definitely a public relations program, this gives local citizens throughout Indiana an opportunity to meet the president and to hear from him personally concerning the attitudes and philosophies of ISMA today. So often the public and your patients are recipients of third or fourth hand information. Such visitations would do much to correct these erroneous and false concepts.

Pre-trial discussions to avoid malpractice suits were encouraged by the Commission on Inter-Professional Relations in cooperation with the Indiana State Bar Association. The Bar Association has shown interest in developing a program of cooperation and this matter is being pursued in greater depth by the Commission on Medical Economics and Insurance and the Medical-Legal Committee.

Medical, lay and professional workers and leaders in voluntary health agencies' activities throughout Indiana continue to work cooperatively with the Commission on Voluntary Health Agencies. This commission has provided a format for greater understanding between these state groups which have in their organizational structures the leadership of people who guide the socio-political-economic attitudes of Indiana citizens who are the profession's patients. The Commission on Voluntary Health Agencies will climax their year by initiating the annual convention through a cooperative two-day program with the American Medical Association's Council on Voluntary Health Agencies. Approximately 12 states will participate. Leaders of voluntary health agencies throughout the state and nation will attend.

An ISMA Speakers Bureau is now being organized by Commission on Medical Education and Licensure. Serving on this bureau will be officers of the association, speakers of pharmaceutical manufacturing companies, and individual physicians. The bureau may be utilized by county medical societies, lay groups, students, and other professional organizations. Subjects will be listed and will involve many areas of interest. One physician has listed his subject as "Medicine in Central Indiana-Rural-Nineteenth Century." Another good public relations program start.

Malpractice problem in Indiana is being studied intently by the Commission on Medical Economics and Insurance. A package program of many insurances for the membership is in the offing. Careful scrutiny and study is being given to every phase of the malpractice insurance project and may well result in another excellent and timely service for member physicians of ISMA.

Sex education in the schools of Indiana has been of primary concern to the Commission on Public Health. This commission is urging a stand by the profession in Indiana which encourages more active participation by physicians in local planning. It's this commission's feeling that sex education is a part of medical practice, and has been so, limitedly, in the past. The commission feels there is a need for organized medicine to become more active in planning for courses and instructors.

A physician is needed to guide and direct medical staff and facilities in Indiana's prisons and reformatories. The Commission on Governmental Medical Services continues to support this concept, which has been a policy of ISMA for years, with every effort of achieving such a plan meeting with defeat. Perhaps with continued perseverance this may be achieved. It's a matter which gets little or no attention from the public press, unfortunately.

Problems of the Legislative Commission come naturally. Each biennium they are faced with reviewing hundreds of bills which deal with the health and safety of Indiana's citizens. This commission has a heavy schedule of work every biennium and meets its responsibilities with vigor.

The Indiana State Board of Health, the Indiana University School of Medicine, other professional associations and voluntary health associations look to them for guidance and support.

Problems of foreign medical students occupied much of the Commission on Special Activities' time. Dr. Antonio Donesa, secretary, National Foreign Graduate Association, met with this group to inform them of the association's activities and to contribute to the commission's discussion. At this meeting a number of misunderstandings were cleared. Many commissions have accomplished similar goals throughout the year. It is one of the unpublished accomplishments of every commission at one time or another.

That limitation of earnings for the aged inhibits healthful and enjoyable activity and promotes a negative outlook is a position taken by the Commission on Aging. Dr. George E. Davis, executive director of the Indiana Commission on the Aging and Aged, met with the commission throughout the year and endorsed the concept. The problems of the aging continue to grow and this commission finds itself with an increasing amount of activity annually.

Plan for the design and establishment of directional highway route markers to emergency facilities was achieved by the Commission on Emergency Medical Services. The United States Department of Transportation has given approval for the association to proceed with the pilot study of use of these signs in a ten-county area of northeast Indiana. Funding is the problem now and the commission is making efforts to secure funds so they might proceed. The public relations value of this program is obvious. A story released by the association received wide comment from throughout the state and the plan has captured national attention.

Merging of all medical organizations into a single federation under the ISMA is being endorsed by the Future Planning Committee. The committee supports the idea of a continuing study in this area and is planning to proceed with the idea, if the House of Delegates approves. What will eventually happen is anybody's guess, but this commission, charged with the responsibility of future plans, is thinking ahead. The merger may eventually come about.

Newly activated Commission on Sports and Medicine, in cooperation with the Indiana University School of Medicine, sponsored and participated in a special one day postgraduate course on "Sports Medicine for the Physician." Among subjects discussed were pre-school conditioning, nutrition facts and fallacies, head and neck injuries, heat exhaustion, knee injuries and others. Participating with them were coaches and directors of athletics.

In addition, our officials, commission members and staff have been involved in the following programs and activities which I will not elaborate upon:

1. Preceptor Program
2. Orientation for New Members Program
3. Annual County Society Officers Conference
4. Journalism Award Program
5. Indiana Youthpower Conference
6. Annual Convention Planning
7. Three Day High School Health Program
8. Thirty Minute Film on Preceptorships
9. Cooperative Program with Indiana Public Health Association
10. Comprehensive Health Planning
11. Supervision of Indiana State Medical Association Field Service
12. Washington, D.C., Legislative Contact Trips
13. Continued Contacts with State Legislators
14. OCHAMPUS Claims Review and Payment
15. Collection of Dues
16. Maintenance of Membership Files
17. Meetings of the Board of Trustees
18. Meetings of the Board's Subcommittees
19. Meetings of the AMA
20. Special Projects of the Board of Trustees
21. Special Projects and Meetings of the President
22. Press Interviews and Releases
23. Provision of Materials and Literature to Groups, Teachers, Students and Physicians
24. Meetings with Student AMA
25. Maintenance of Building
26. Direction of Staff
27. Meetings with Committees of Allied Health Groups
28. Meetings of Student Loan Committee
29. Meetings of Grievance Committee
30. Political Action Committee Meetings

These then are just a few of the highlights of the year's work by some of the commissions and a listing of some of the additional activities. Some commissions met more often than others. Some were better attended than others. But behind each accomplishment was considerable contribution of time and interest by participating physicians.

So often the statement is made that nothing is being done by the ISMA, but as your executive secretary, I feel that much is being accomplished in many areas which are given little or no notice by the general membership.

These activities and accomplishments are necessary to the continued growth of ISMA as a strong contributing organization to health needs and demands. My wish, and I know I express the feelings of our officers, is that when a member accepts a responsibility with a commission that he attend and contribute to its proceedings and assist in developing positive action programs from commission recommendations.

I would like to add, too, that every activity involves the work and support of the staff, who assist in researching projects for commissions, planning proper meeting facilities, making additional special arrangements, and contributing in every way possible to the needs of each committee and commission.

Membership—Your secretary believes an analytical report of the membership of the association showing the trends might be of interest to the House. I realize that statistics are boring but I know of no other way that figure presentation can be made.

While the association has continued to grow in membership, the net growth has been extremely small and the projection made in 1960 by Indiana University which projected a need for 6,000 practicing physicians in Indiana by 1970 is far from being met. Many groups have discussed the retention problem of physicians. Many small communities are seeking physicians and at the present time we are unable to supply the apparent need for physicians in our state.

Your secretary believes this is a matter which should be of concern to the association and would like to suggest that a study be made of the possibility of a continued advertising campaign in densely populated areas to determine if physicians from other areas might be enticed into the state.

At the present time, based on 1967 figures, we have one patient care physician for each 1,097 individuals. If we add to this figure the total of all physicians, those who are providing patient care and those who are in research, administrative work, etc., it brings our average down to one physician for each 999 people. In 1965 our ratio of patient care physicians to population figured one physician to each

1,091 people, so on this basis, it is indicative that physician supply is not keeping pace with the population growth of our state.

Listed below, for your information, is a comparison in practice changes between the year 1964 and 1967 of the various specialty groups, including general practitioners.

SPECIALTY	1964	1967
General Practice	1835	1772
Medical Specialties (Total)	628	663
Allergy	15	17
Cardiovascular	16	19
Dermatology	43	48
Gastroenterology	1	1
Internal Medicine	376	396
Pediatrics	153	165
Pediatric Allergy	1	0
Pediatric Cardiology	2	1
Pulmonary Diseases	21	16
Surgical Specialties (Total)	1140	1231
General	410	432
Neurological	25	28
OB-GYN	208	213
Ophthalmology	155	171
Orthopedic Surgery	125	137
Otolaryngology	99	99
Plastic Surgery	15	21
Colon-Rectal	12	13
Thoracic	10	17
Urology	81	100
Other Specialties	784	850
Anesthesiology	173	199
Child Psychiatry	5	9
Forensic Pathology	0	1
Neurology	18	18
Occupational Medicine	43	41
Psychiatry	149	163
Pathology	120	120
Physical Medicine & Rehabilitation	2	6
General Preventive Medicine	6	5
Public Health	10	9
Radiology	156	182
Unrecognized	7	9
Unspecified	95	88

Another figure which might be of interest to the House is that in 1964, 90.4% of all physicians in Indiana were members of ISMA. Of the physicians rendering patient care for that year, 99.5% were members of the association. In 1965, 89% of the total physicians were members and 98.4% of the physicians rendering patient care were members. In 1966, 89.8% of the total physicians were members and of the physicians rendering patient care, 98.6% were members. For the year 1967, of the total physicians 89.1% were members and of the physicians rendering patient care 97.8% were members.

Another tabulation which might be of interest to you is the change in physician population by our medical districts. The columns below indicate the membership by medical districts for the year 1964 as compared to the membership for 1968. The third column indicates the number of physician members at the end of June 30, 1969. It is of concern that in 1964 we had 4,364 members and at the end of 1968, 4,440 for a net gain during that period of 76 and an average of 19 new physicians per year.

District	1964	1968	6 Mo. 1969
1	286	273	273
2	150	165	169
3	157	165	171
4	137	136	140
5	171	163	164
6	185	179	176
7	1137	1144	1134
8	249	256	253
9	254	264	261
10	463	512	509
11	246	237	241
12	416	430	442
13	513	516	507

It might be interesting also to note that Indiana physicians who are members of the AMA increased from 4,256 at the end of 1964 to 4,286 by the end of 1968 and at the end of the first six months of 1969, AMA membership stood at 4,290.

Retention of physicians is a problem in other states. One of the Midwestern states, at their annual meeting, adopted two resolutions concerning the retention of physicians in their state. One resolution adopted called upon their medical school to refuse to accept as a student one who would not agree to serve a specified number of years in medical practice within that state.

The other resolution was that tuition charges be cancelled on a year to year basis for physicians who remained in practice in their state.

Another resolution in the same state called upon the association to finance an active program designed to sell the students' wives on the pleasures of life in the smaller towns of their state.

For your consideration, your secretary has informally discussed the following for the past year and a half but there are some matters of the future which should now have your attention and have your attention in the next months so that you and your staff will not be caught short on determination of policy.

I think you all recognize that there is going to be confronting you and confronting the public a tremendous growth in the numbers of paramedical personnel and there is going to be a growth in the number of those who hold themselves as a separate discipline akin to law, akin to medicine, but a separate discipline not within the borders of either. I feel it necessary to say to you that I think the matter of privileged communication, traditionally that of the medical profession, the lawyer and the clergy, should be reviewed in depth as to the extent it should be extended to the other fields coming into being.

And as we consider that matter, I think we should also consider the standards of malpractice that may be applied to the technicians and to the members of "other disciplines." You are seeing the limited licensee and the certified technician entering the hospital corridor. It is probably not a real problem as yet. But who knows? What patient is able to identify a person within the hospital staff and his responsibility and his liability?

And as you think of that, think of the problem attendant upon the keeping of notes. This has been your problem primarily with reference to nurses' notes. But as the psychologist enters the hospital (and he will, one of these days), and as a technician enters who is not strictly within the field of remedial medicine, are their notes to be put on the patient's record? And are those notes to have some relationship, at least in the matter of liability?

Also, you have certainly read in your various journals that the assistant doctor is about to come upon the scene. What is his liability? What is his privilege? What is his responsibility to you, the medical profession?

These, I think, are some of the challenges to you as physicians. I do suggest that we begin giving earnest consideration to some of the coming events which are on the horizon.

I want to thank the officers for their assistance and guidance, to thank every physician who served faithfully this year and further express my appreciation to the staff who also gave unstintingly of time, thought and industry.

JAMES A. WAGGENER,
Executive Secretary

The Treasurer

HOUSE ACTION: Approved.

The 1969 fiscal year ended on September 30th and while we are meeting in convention the auditors are busy auditing our association records for the past year. I am sorry it is impossible to give you the audit figures for this year at this time but I am incorporating, as a part of this report, the annual audit for the fiscal year ending September 30, 1968. I can, however, give you a statement of the cash and invest-

ments and totals of all funds of the association for the first nine months of the year ending July 31, 1969.

SUMMARY OF ALL FUNDS

	Cash	*Investments*	*Total*
General Fund	$2,833.04	$326,215.51	$329,048.55
Journal Fund	14.43	—	14.43
Medical Defense Fund	5,264.46	25,000.00	30,264.46
Building Fund	6,464.93	—	6,464.93
Woman's Auxiliary Donation	—	4,054.96	4,054.96
Student Loan Fund (Old)	1,410.59	12,911.92	14,322.51
Ducs Account	13,365.29	—	13,365.29
Kitchen Fund	—	5,609.71	5,609.71
Total all funds	$29,352.74	$373,792.10	$403,144.84

Comparing this with the same period of 1968, we had a total cash on hand of all funds of $53,071.43 as against $29,352.74 at the end of July 31, 1969 for a loss of $23,718.69. This change is brought about by the fact that we are attempting to keep as much of our cash in short term investments to earn as much as possible during the time when the funds are not needed for use. Our investment account as of July 31, 1968 amounted to $306,373.35 as against $373,792.10 at the end of July 31, 1969 for an increase in investments of $67,413.75. The total cash and investments of all funds as of July 31, 1968 amounted to $359,449.78. The comparable figure for July 31, 1969 is $403,144.84, showing an increase of $43,695.06.

The treasurer has consulted with the Executive Committee and the Board of Trustees who have reviewed the cash and investment portfolio of the association at each of their meetings. The treasurer has followed the advice of these bodies by investing all available cash in short term bills or savings accounts in order to accumulate as much interest as possible where funds were not required for current purposes.

LESTER H. HOYT, M.D.
Treasurer

INDIANA STATE MEDICAL ASSOCIATION

Financial statements for the year
ended September 30, 1968
with
supplementary data

Board of Trustees,
Indiana State Medical Association,
Indianapolis, Indiana.

We have examined the statement of financial condition of the Indiana State Medical Association as of September 30, 1968, and the related statements of income and expense of the general fund and changes in fund balances for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying statements present fairly the financial position of the Indiana State Medical Association at September 30, 1968, and the results of its general fund operations and changes in fund balances for the year then ended in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

The accompanying supplementary information has been subjected to the tests and other auditing procedures applied in the examination of the financial statements mentioned above and, in our opinion, is fairly stated in all material respects in relation to the financial statements taken as a whole.

Geo. S. Olive & Co.
Certified Public Accountants

Exhibit A

INDIANA STATE MEDICAL ASSOCIATION

Statement of General Fund Income and Expense

	Year Ended September 30		
	1968 Budget	1968 Actual	1967 Actual
INCOME—notes 1 and 2:			
Dues	$309,622	$314,962.50	$312,701.25
Less: Dues allocated as follows:			
Building fund	38,850	39,120.00	38,790.00
American Medical Education fund	19,425	19,500.00	19,395.00
The Journal	31,960	32,176.00	31,944.00
Medical Defense fund	4,856	4,892.50	4,848.75
	95,091	95,688.50	94,977.75
Dues available for general fund operations	214,531	219,274.00	217,723.50
Other income:			
Interest income on investments	8,000	11,000.44	9,070.97
Received from American Medical Association	2,500	2,737.08	2,572.63
The Journal—net income—schedule A-1	277	5,263.79	4,306.24
Miscellaneous	27,000	1,654.79	1,480.20
	252,308	239,930.10	235,153.54
EXPENSE:			
Committees and commissions—schedule A-2	14,450	11,675.98	22,997.24
Officers and Council—schedule A-2	33,250	36,522.63	31,691.63
Headquarters office—schedule A-3	166,719	155,167.21	153,045.95
Annual meeting expense (income)—schedule A-4	1,000	3,835.90	(195.46)
Membership expense	6,000	9,411.02	-----
Dues, subscriptions and donations	3,500	4,326.99	3,384.07
Employees' retirement expense	9,500	8,237.30	9,875.88
Loss on guaranteed student loans	-----	2,519.54	-----
	234,419	231,696.57	220,799.31
NET INCOME	$ 17,889	$ 8,233.53	$ 14,354.23
ALLOCATED AS FOLLOWS:			
General fund—exhibit C		$ 14,220.61	
Building fund—exhibit C		(5,987.08)	
		$ 8,233.53	

The accompanying notes are an integral part of this statement.

INDIANA STATE MEDICAL ASSOCIATION

Statement of Financial Condition at September 30, 1968

ASSETS

General Fund:			
Cash on deposit and on hand		$ 43,763.03	
Certificates of deposit		150,000.00	
U. S. Treasury bonds (market value $45,960)		55,102.22	
Investment in mutual fund		25,078.90	
Securities and cash in escrow account		3,000.00	
Accounts receivable		8,004.68	
Reimbursement due from U. S. Government for processing Champus claims		2,863.62	
Prepaid expenses and miscellaneous assets		7,214.03	
Office furniture and equipment—at cost	$ 67,767.07		
Less: Accumulated depreciation	33,341.27		
		34,425.80	
			$329,452.28
Building Fund:			
Cash on deposit		4,823.10	
Cash in savings account		4,054.96	
U. S. Treasury bills—at cost plus earned discount		24,710.35	
Prepaid expense		402.33	
Meridian Street property:			
Land	69,187.60		
Office building	$299,354.38		
Less: Accumulated depreciation	38,634.06		
	260,720.32		
		329,907.92	
Rental properties—at cost (net of $4,776.28 of accumulated depreciation)		88,381.72	
Due from general fund		832.60	
			453,112.98
Student Loan Fund:			
Cash in savings account		14,177.08	
Certificates of deposit—note 3		20,810.00	
Notes receivable from students		5,012.92	
			40,000.00
Medical Defense Fund:			
Cash on deposit		2,750.04	
U. S. Treasury bonds plus accrued interest receivable		25,373.80	
Due from general fund		960.53	
			29,084.37
Champus Fund (formerly Medicare):			
Cash on deposit		8,888.10	
Reimbursement due from U. S. Government for advance payments made to doctors		65,611.90	
			74,500.00
			$926,149.63

The accompanying notes are an integral part of this statement.

Exhibit B

LIABILITIES AND FUND BALANCES

General Fund:			
Accounts payable		$ 10,759.11	
Accrued payroll and property taxes		11,201.91	
Allocation of dues payable to American Medical Education and Research Fund		19,500.00	
Advances from American Medical Association		10,319.19	
Unearned portion of 1968 dues		73,443.75	
Exhibitors' deposits for 1968 annual meeting		15,488.75	
Due to other funds:			
Building fund	$832.60		
Medical Defense fund	960.53		
		1,793.13	
Fund Balance—exhibit C		186,946.44	
			$329,452.28
Building Fund:			
Loans from members (non-interest bearing)		22,825.00	
Accrued property taxes		2,091.33	
Guarantee and damage deposits		425.00	
Fund balance—exhibit C		427,771.65	
			453,112.98
Student Loan Fund:			
Fund balance—exhibit C:			
Principal balance appropriated from general fund—note 3		40,000.00	
			40,000.00
Medical Defense Fund:			
Fund balance—exhibit C		29,084.37	
			29,084.37
Champus Fund:			
Fund balance (cash advanced by U. S. Government)—exhibit C		74.500.00	
			74,500.00
			$926,149.63

Exhibit C

INDIANA STATE MEDICAL ASSOCIATION

Statement of Changes in Fund Balances, Year Ended September 30, 1968

	General Fund	Building Fund	Student Loan Fund	Medical Defense Fund	Champus Fund
Balances, October 1, 1967	$177,203.88	$394,444.97	$40,000.00	$32,247.51	$75,000.00
Additions:					
Net income year ended September 30, 1968—exhibit A	14,220.61	(5,987.08)			
Dues allocated to restricted funds		39,120.00		4,892.50	
Other income credited directly to restricted funds		734.73		1,008.15	
	14,220.61	33,867.65		5,900.65	
Deductions:					
Prior years' adjustments charged directly to fund balance	4,478.05				
Expenses charged directly to restricted funds:					
Building fund:					
Rental property expense (net of rental income of $5,100)		540.97			
Medical Defense fund:					
Legal fees				3,925.00	
Malpractice defense fees				5,138.79	
Funds returned to U. S. Government					500.00
	4,478.05	540.97		9,063.79	500.00
Balances, September 30, 1968—exhibit B	$186,946.44	$427,771.65	$40,000.00	$29,084.37	$74,500.00

The accompanying notes are an integral part of this statement.

INDIANA STATE MEDICAL ASSOCIATION

Notes to Financial Statements at September 30, 1968

NOTE 1—GENERAL PURPOSE AND NATURE:

The Association was organized as the Indiana State Medical Society in 1849. The Articles of Incorporation were amended in 1926 to change the name to the Indiana State Medical Association.

The purposes for which the Association was formed were to extend medical knowledge; advance medical science; elevate standards of medical education; enlighten the public in regard to problems of medical care, public health, cure of disease; thereby prolonging and adding comforts to life.

The Association is exempt from the payment of federal income tax (except on unrelated business income) under the provisions of section 501 of the Internal Revenue Code as an organization formed and operated to promote the objectives outlined above.

NOTE 2—METHOD OF ACCOUNTING AND BASIS OF ASSETS:

The Association maintains its books and records on the accrual basis. Investments in securities, rental properties and various other assets reflected in the statement of financial condition are carried at cost if purchased or at market value at date of receipt if acquired by gift. Unless stated otherwise, the market value of investments approximates cost.

Depreciable assets are carried at cost and are depreciated on the straight-line method with such depreciation charged as a general fund operating expense.

The assets, liabilities and operations of *The Journal*, the Association's monthly publication, are reflected as a part of the general fund in the accompanying financial statements. The budget for the year ended September 30, 1968 has been adjusted to include the operations of *The Journal* and for various equipment expenditures which have been capitalized and are being depreciated as indicated above.

NOTE 3—STUDENT LOAN FUND PRINCIPAL:

The Student Loan fund is a separate irrevocable charitable trust established in October, 1955, for the purpose of making loans to medical students. The assets and equity of this trust are included in the accompanying financial statements in order to reflect the fiduciary responsibilities of the Indiana State Medical Association as trustee of the fund. This loan fund was created and funded through cash appropriations from the general fund totaling $40,000 over a five-year period beginning in May, 1956.

INDIANA STATE MEDICAL ASSOCIATION

Notes to Financial Statements at September 30, 1968

Under the terms of an agreement with The Indiana National Bank of Indianapolis, the bank is making loans to students enrolled and in satisfactory standing at the Indiana University Medical School at the rate of twelve and one-half dollars for each dollar placed in a capital reserve at the bank. As of September 30, 1968, the bank held $20,810 in this capital reserve (represented by certificates of deposit) thereby producing an available loan balance approximating $260,000, of which $15,800 had been loaned to medical students. The Association is contingently liable for these latter loans to the extent of the collateral only.

The Executive Committee, in conjunction with the Student Loan Committee, is to review the student loan situation annually for the purpose of authorizing further general fund appropriations to the loan fund as additional funds are needed to guarantee loans under the agreement with The Indiana National Bank.

SUPPLEMENTARY DATA

Schedule A-1

INDIANA STATE MEDICAL ASSOCIATION

The Journal Statement of Operations

	Year Ended September 30		
	1968 Budget	1968 Actual	1967 Actual
INCOME:			
Subscriptions—members	$31,960	$32,176.00	$32,600.00
Subscriptions—non-members	1,000	1,902.00	1,520.00
Advertising	50,000	55,905.95	50,926.27
Other	3,000	5,827.41	3,606.05
	85,960	95,811.36	88,652.32
EXPENSE:			
Salaries, commissions and outside help	20,000	19,987.89	19,267.82
Printing and reprints	49,000	54,311.03	49,746.80
Engraving, art work and photographs	5,000	5,361.32	5,088.85
Office supplies and postage	700	584.23	545.98
Travel and meeting expense	1,800	1,710.11	1,684.19
Bulk mailing	1,500	1,583.28	1,455.61
Other publishing expense	600	772.40	579.30
Payroll taxes	500	477.56	486.26
Rent and utilities	3,450	3,408.00	3,408.00
Telephone and telegraph	450	359.11	367.64
Insurance and retirement	750	694.25	690.75
Equipment replacement	800	-----	-----
Cash discounts allowed and miscellaneous	1,133	1,298.39	1,015.88
	85,683	90,547.57	84,346.08
NET INCOME—exhibit A	$ 277	$ 5,263.79	$ 4,306.24

Schedule A-2

INDIANA STATE MEDICAL ASSOCIATION

Analysis of Operating Expense—
Committees and Commissions—Officers and Council

	Year Ended September 30		
	1968 Budget	1968 Actual	1967 Actual
COMMITTEES AND COMMISSIONS:			
Standing committees:			
Grievance	$ 250	$ 223.11	$ 161.00
Student Loan	50	32.64	11.40
Future Planning	300	101.74	70.42
Commissions:			
Constitution	300	495.97	107.00
Inter-Professional Relations	300	70.10	236.00
Legislation	300	494.04	2,341.42
Public Health	400	285.74	449.40
Public Information	600	198.48	-----
Special Activities	300	341.41	298.55
Voluntary Health Agencies	400	345.96	303.44
Medical Economics and Insurance	300	457.21	609.72
Medical Education and Licensure	300	410.53	338.71
Governmental Medical Services	300	322.54	126.99
Aged and Aging	350	615.90	255.23
Education	7,500	6,108.66	13,001.77
Special programs and miscellaneous	2,500	1,171.95	4,686.19
Totals—exhibit A	$14,450	$11,675.98	$22,997.24

OFFICERS AND COUNCIL:			
President	$ 6,500	$ 5,853.92	$ 4,205.70
President-elect	750	1,045.20	624.80
AMA meetings	15,000	18,322.79	14,320.44
Treasurer's office—auditing	2,500	2,435.00	2,475.00
Council chairman and Council meetings	7,500	7,944.74	9,162.08
Executive Committee meetings	1,000	920.98	903.61
Totals—exhibit A	$33,250	$36,522.63	$31,691.63
Depreciation	----	10,394.77	13,593.44
Champus expense in excess of reimbursement	----	4,149.36	9,872.68
Miscellaneous	1,000	947.51	621.58
Totals—exhibit A	$166,719	$155,167.21	$153.045.95
		10,394.77	
		144,772.44	

Schedule A-3

INDIANA STATE MEDICAL ASSOCIATION

Analysis of Operating Expense—Headquarters Office

	Year Ended September 30		
	1968 Budget	1968 Actual	1967 Actual
Salaries	$105,219	$ 85,908.83	$ 74,421.11
Telephone and telegraph	5,500	6,165.85	5,196.19
Postage	5,500	3,988.25	4,361.13
Printing and office supplies	6,000	4,568.88	5,660.97
Travel, entertainment and field expense	14,000	9,880.19	12,484.68
Building operations and utilities	10,000	10,560.73	8,674.28
Insurance	7,000	6,374.22	6,828.91
Extra help	500	98.00	72.50
Payroll taxes	3,000	2,898.97	2,610.48
Property taxes	7,500	7,311.84	7,244.64
Equipment maintenance	1,500	1,924.81	1,403.36

Schedule A-4

INDIANA STATE MEDICAL ASSOCIATION

Analysis of Operating Expense—Annual Meeting

	Year Ended September 30	
	1968	1967
Convention planning	$ 1,640.15	$ 248.79
Speakers' travel and expense	2,500.00	923.02
Technical exhibits, circulars, etc.	1,121.40	678.35
Scientific program and exhibits	645.00	678.35
Programs, handbooks and printing	2,889.94	2,659.56
Badges	295.71	185.40
Meetings—Council and House of Delegates	898.89	192.00
Telephone service	237.35	33.00
Office personnel expenses	458.55	623.66
Plaque awards	218.88	344.62
Prizes—annual meeting	151.50	123.95
50-year club	79.57	158.84
Photography	365.00	358.50
Banquet, luncheon and party	7,278.66	840.00
Miscellaneous	1,315.30	3,869.00
	20,095.90	11,917.04
Less: Income from exhibitors' booths	16,260.00	12,112.50
Excess of expense (income)—exhibit A	$ 3,835.90	$(195.46)

Chairman of the Board

HOUSE ACTION: Approved.

For the Board, the chairman wishes to express his thanks to the president, president-elect, to the chairman and the other members of the Executive Committee for their splendid spirit of cooperation that has prevailed during the past year. The headquarters staff has been most helpful on every occasion when I requested their aid; Mr. Jim Waggener especially left no stone unturned to aid the Board in its work.

Personally the chairman wants to thank the individual members of the Board for allowing him to serve as their chairman during the past year. This has been a most gratifying experience—one which makes a person feel quite humble when he is confronted with the individualism of the 12 other trustees.

The chairman specifically wants to bring to the attention of the House of Delegates the very high rate of attendance and participation by the various trustees. Attendance this year has been higher than any other year during my tenure on the Board. In addition the alternate trustees have also shown a higher attendance rate than ever before. There were very few times when each trustee district was not represented.

By the time of the annual meeting, the Board will have held seven meetings. Two of these were especially noteworthy because of their content. In January, the Board held a joint meeting with selected members of the faculty of the I.U. School of Medicine who were chosen by Dean Glenn Irwin. Two areas of discussion were presented by members of the faculty: namely, Medical School Admissions Standards and Procedures; secondly, the new medical school core curriculum. There was a free exchange of ideas between the two groups and the Board felt that this was a very worthwhile project.

In March the Board met in Chicago for a four-day session. The first two days were devoted to regular form business and also to participation in an intensive public-speaking course conducted by the Public Information Division at AMA headquarters.

During the last two days the Board attended the AMA Congress on Socioeconomics of Medicine. The main topic at this year's congress was the various means and methods of health care delivery. The experience was very meaningful to the Board.

The headquarters staff completed and distributed to the Board members a pamphlet index on the quotation "Authority and Responsibilities of the Duties of the Board of Trustees of ISMA." This should prove quite helpful to the Board members.

The Board continued to function to a greater extent through the committee system. This allows the Board to be much better informed in that individual members can become more knowledgeable in specific areas; the various committees can bring specific recommendations to the Board with all the investigating work done beforehand. This also proves to be a time-saver to the Board as it becomes increasingly busier.

The chairman hopes that the committee system can become more broadly developed as time goes by. However, the Board must be careful that it does not usurp unto itself or any of its committees such executive duties that are properly the function of the president and his headquarters staff.

Dr. Reid's Committee on Medical Use of Computers and Dr. McIntosh's Committee on Governmental Medical Programs are especially to be commended on their fine work. Dr. Clark's Committee on Orientation of New Members presented a very worthwhile program at Fort Wayne in 1968, and this activity should be continued.

The Board considered several items on which they will undoubtedly submit resolutions to the House of Delegates. The Board feels that in order to meet the increasing cost of maintaining the headquarters due to inflation and in order to consider several new programs, an increase in dues will probably be necessary.

The House at the 1968 convention mandated the Board to submit a recommendation on revision of trustee districts. This was in reponse to Resolution 68-10. Similar resolutions were introduced in 1958 and 1966. An ad hoc committee of the Board is considering this matter and the Board will have a report to the House on its findings.

During the past year representatives of the Indiana University Chapter of the Student American Medical Association have been invited to the Board meetings and to various commission meetings. Attendance and participation have been good. At a recent Board meeting, the president of I.U.-SAMA requested that we consider giving their chapter representation in the House of Delegates. The Board feels that this should be considered by the House of Delegates.

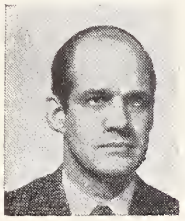
The Board approves, subject to confirmation by the House, that ISMA hold a Health Week in the spring of 1970 to which high school students from throughout the state be invited to Indianapolis to hear capable speakers on various subjects relative to health and of interest to today's youth. This is a program which the Board feels is very worthwhile but which would undoubtedly require more financial support than our present income will provide.

The chairman attended eight of the 11 district meetings that were held this spring. At each of these the district trustee and the district officer went to considerable effort and in some instances considerable expense to put on a good program; however, in nearly every case, attendance was poor or worse. Nearly every district attendance was certainly less than ten percent of the membership. This is extremely distressing when one considers that important decisions are being made at these meetings in which so few of the members participate. The district trustees and the district Blue Shield board members are elected at the district level. Certainly no member can criticize the decisions of his representative if he will not take part in the democratic process by which these representatives are elected. The House may want to consider methods whereby this situation can be corrected.

DONALD R. TAYLOR, M.D.,
Chairman

First Trustee District

HOUSE ACTION: Approved.



GILBERT M. WILHEMUS, M.D.,
Trustee

The annual meeting of the First District Medical Society was held May 22, 1969, at the Evansville Country Club. The meeting was well attended by members and their wives.

Mead Johnson & Company was host for our social hour preceding the dinner. Mr. Miller, a national distillery representative from New York City, talked on the subject of wines, the history and their enjoyment. Dr. George W. Willison, Blue Shield director, reported to the group; and Dr. Gilbert M. Wilhelmus reported the past and present business activities of the Indiana State Medical Association. After the meeting the following officers were elected: James Hobgood, M.D., president; Fred Smith, M.D., vice-president; and Raymond Burnikel, M.D., secretary-treasurer.

The Vanderburgh County General Practice Group was host to the Indiana Academy of General Practice state convention this year, and the large group of physicians who attended the convention were impressed with the state meeting and also the new civic center where the convention was held.

The Vanderburgh County Medical Society has worked very diligently this year, particularly in the mental health field.

GILBERT M. WILHEMUS, M.D.,
Trustee

Second Trustee District

HOUSE ACTION: Approved.



JOE DUKES, M.D.,
Trustee

Your trustee has been active this past year attending all scheduled meetings of the Board of Trustees, in addition to several other meetings of related interest: the socioeconomic program in Chicago last March, the conference of County Medical Society Officers, along with Blue Shield activity especially concerned with comprehensive health.

The second district meeting was held this year at the Country Club in Sullivan on May 22nd. The scientific program was put on by Indiana University and the Mental Health Association.

The program was: "Psychiatry In Everyday Practice," moderated by Dr. Betty J. Dukes. Lecturers: William Vance, M.D.; Hanus J. Grosz, M.D. and James J. Wright, M.D. Subjects were: "Depression," "Alcoholism" and "The Suicidal Patient."

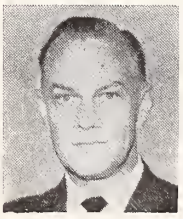
At the business meeting Dr. J. S. Brown of Carlisle was elected secretary for the district for the 47th time and Dr. Joe Dukes of Dugger was re-elected trustee for his second term.

Dr. Vance Chattin on behalf of the Knox County Medical Society invited the district meeting to be held in Vincenes next year.

JOE DUKES, M.D., *Trustee*

Third Trustee District

HOUSE ACTION: Approved.



DONALD M. KERR, M.D.,
Trustee

The Third District meeting was held at the Robert E. Lee Motel in New Albany on the first Wednesday in April. The meeting was under the direction of Dr. Daniel Cannon, Third District president, who was re-elected to district presidency. Special guests were Dr. Donald Taylor, chairman of the Board of Trustees and Dr. Malcolm Scamahorn, assistant treasurer, ISMA.

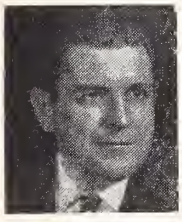
The program, which was well attended and of obvious interest, dealt with problems of human sexuality and was additionally noteworthy for the large number who stayed until the final evening sessions were terminated.

Once again in the district was seen the tragedy of good physicians falling into the trap of narcotics addiction with resultant loss to themselves, their families, their community and their profession. Your trustee urges all physicians to be ever mindful of the ease with which those who deal daily with such drugs seem to develop a contemptuous familiarity, and of the ensuing tragedy.

DONALD M. KERR, M.D., *Trustee*

Fourth Trustee District

HOUSE ACTION: Approved.



ROBERT M. REID, M.D.,
Trustee

The district meeting of the fourth district was held at Batesville, Indiana, on May 14. Attendance was fairly good. The program, in addition to golfing and social activities, included several physicians who presented scientific papers. The speakers were: Leon Goldman, M.D., Professor of Dermatology, University of Cincinnati; Bruce G. McMillan, M.D., Shrine Professor of Surgery and Chief of Staff of the Burn Unit, University of Cincinnati; and John I. Nurnberger, M.D., Chairman of the Department of Psychiatry, Indiana University School of Medicine.

The delegates' meeting was attended at a level barely above quorum. Those present participated in a discussion of district matters; the present status of comprehensive health planning in our district; possible alternatives available in the attempt to meet the many problems in the delivery of health care with particular reference to the relatively rural area; the continuing concern regarding diminishing interest of district activities and the possible applications of a $10 assessment voted for district members at the 1968 meeting. The unusually high number of follow-up contacts pertaining to this discussion has been encouraging.

As a representative of so-called organized medicine, I continue to be concerned about the minimal degree to which the membership looks to its organization for leadership. It seems incredible that so many dedicated and capable individuals have given so generously of time and talent with the results that are apparent to nearly all of us today. It is obvious either we are not addressing ourselves to the vital interests of the membership or that we have not earned the confidence that we can deal effectively with these interests.

I believe profoundly that the great majority of physicians are genuinely and primarily concerned with the effective delivery of health care to their patients. I believe that this should be the prime concern of our organization. I hope and am encouraged to believe that imaginative and promising departures, with a strictly traditional organizational effort, will offer new and rewarding interests within the next several months and years. I would hope that we will see a vigorous and enlightened reaction to our many challenges formulated by and executed by physicians, individually and collectively. If we do not, we will forfeit the very justification of our existence.

ROBERT M. REID, M.D., *Trustee*

Fifth Trustee District

HOUSE ACTION: Approved.



WILBERT McINTOSH, M.D.,
Trustee

This district meeting was held at the Terre Haute Country Club April 30, 1969. The afternoon session of the meeting was called to order at 4:00 p.m. by Dr. Herzberg, Clinton, Indiana.

Reports were made from various committees. Mr. Dixon reported on the progress of Blue Shield; Mr. Amick, field man, made a brief report.

A discussion was held and a committee appointed to investigate methods of invigorating and increasing the interest and attendance of the local districts. The committee is to contact other districts in Indiana to facilitate this. The meeting was adjourned for dinner.

Dr. Andrew Offutt was the after-dinner speaker; his subject was "Comprehensive Health Planning." The visiting dignitaries at the dinner meeting were Dr. Malcolm Scamahorn and Dr. Donald Taylor, both of whom are candidates for the next presidency of the Indiana State Medical Association.

Election of officers was held. The new officers: Dr. William Tipton, Greencastle, president; Dr. Cleon M. Schauwecker, Greencastle, secretary-treasurer.

The next annual meeting will be held at Greencastle, Indiana at a date to be determined later.

WILBERT McINTOSH, M.D., *Trustee*

Sixth Trustee District

HOUSE ACTION: Approved.



STEPHEN D. SMITH, M.D.,
Trustee

This year's activities in the Sixth District Medical Society area, which includes the medical societies in the area known as "God's Country" along Little Blue River and East, i.e., Hancock, Rush, Shelby, Fayette, Union, Wayne and Henry Counties —was culminated by a spirited meeting at Richmond the 1st day of May, 1969. This meeting started with a tour and a lecture of the Reid Memorial Intensive Cardiac Care Unit and also of the Acute and Chronic Respiratory and Inhalation Therapy Department. These discussions were led by Drs. Linn and Ramsdell, respectively.

Following the afternoon of intellectual stimulation, there was a business meeting for the Sixth District with Dr. Stephen D. Smith, president, as the presiding officer. A short discussion of problems concerning malpractice legation was presented by Shelby County following which it was moved and seconded that this be further investigated. Following this, elections were held for the coming year which were: Dr. Perry Seal, Brookville, president; Dr. David Wynegar, Richmond, vice-president; Dr. Mark Smith, New Castle, secretary and treasurer and Dr. Frank Green, alternate trustee. The place of the 1970 meeting will be Westwood Country Club, New Castle, Indiana. We were honored by guests representing the state medical society in the persons of Dr. Donald Taylor, Muncie, chairman of the Board of Trustees and Dr. Malcolm Scamahorn, Pittsboro, assistant treasurer. Also honoring us with his presence was Mr. Herbert Dixon of Blue Shield.

This was followed by dinner for the doctors and their wives at which time prizes were awarded to the golfers.

After dinner Dr. Felix Manfredi of the Veteran's Administration Hospital, Indianapolis, gave a discussion, incorporating

visual aids, as to current therapy and approach to the treatment of respiratory failure.

There have been many persons contact me suggesting the possibility of changing the district medical meeting so that there will be better representation of all of the counties involved. Some thought has been generated around the idea of having a meeting of trustee, alternate trustee, and president and secretary of each component county medical society twice a year. This foregoing should be studied in depth for the entire state.

STEPHEN D. SMITH, M.D.,
Trustee

Seventh Trustee District

HOUSE ACTION: Approved.



JAMES A. GOSMAN, M.D.,
Trustee

The annual meeting of the Seventh District Medical Society was held at 7:00 p.m., Wednesday, April 30, 1969, at Marion County General Hospital, in Indianapolis, with the president, Dr. John O. Butler, presiding.

Dr. Butler introduced Dr. Lester D. Bibler, former trustee of the American Medical Association, and Mrs. Bibler; Dr. Hugh K. Thatcher, president of the Marion County Medical Society; Dr. Glen V. Ryan, chairman of the Blue Shield Board of Directors; Mr. Richard C. Kilborn, president of Blue Shield, and Dr. Harold C. Ochsner, former AMA delegate.

Dr. Bibler, with several seconds, moved that the minutes of the previous meeting not be read. The motion was carried.

In the absence of Dr. Donald E. Stephens, secretary-treasurer, Dr. Butler presented the treasurer's report showing a bank balance of $901.75 as of April 30, 1969.

Dr. Butler then called for nominations for president-elect of the society, to serve in 1970-71. Dr. Ryan nominated Dr. Ellery T. Drake, of Martinsville. Dr. Bibler moved that the nominations be closed and that Dr. Drake be declared elected unanimously. The motion was carried.

Dr. Butler asked for nominations for secretary-treasurer. Dr. Edwin S. McClain nominated Dr. Stephens to succeed himself. Dr. Ted L. Grisell then moved that the nominations be closed and that Dr. Stephens be declared elected unanimously. The motion was carried.

Dr. Butler called for nominations for alternate trustee of the Indiana State Medical Association. Dr. Thatcher nominated Dr. Butler to succeed himself and Dr. Robert W. Mouser moved that the nominations be closed and that Dr. Butler be declared elected unanimously. The motion was carried.

Dr. Butler called for nominations for director of Blue Shield. Dr. Thatcher nominated Dr. Ryan to succeed himself. Dr. Mouser moved that the nominations be closed and that Dr. Ryan be declared elected unanimously. The motion was properly seconded and carried.

Dr. Joseph Kerlin, of Danville, president of the Hendricks County Medical Society, presented the following resolution from that organization and his motion, properly seconded, that it be adopted, was carried:

"WHEREAS, Malcolm O. Scamahorn, M.D., of Pittsboro, is an announced candidate for president-elect of the Indiana State Medical Association proposed by the Hendricks County Medical Society, which is vigorously supporting him, and,

"WHEREAS, Dr. Scamahorn has served the local medical society, his profession, his community, the Indiana State Medical Association, as well as the Seventh District Medical Society, long and well,

"THEREFORE, BE IT RESOLVED, that the Seventh District Medical Society endorse the candidacy of Malcolm O. Scamahorn, M.D., of Pittsboro, for president-elect (1969) of the Indiana State Medical Association."

Dr. Butler called for new business and Dr. Thatcher moved that the stipend of the executive secretary be increased to $100 annually. The motion was seconded by several and carried.

The president expressed the appreciation of the society to Dr. Arvine G. Popplewell, superintendent of Marion County General Hospital, for having members and their ladies as guests of the institution for dinner and the meeting, and turned the meeting over to Dr. Scamahorn, incoming president.

Dr. Scamahorn presented Dr. McClain, who introduced Mr. Brian L. Bex, of Bloomington, guest speaker.

Following the address by Mr. Bex, the meeting was adjourned.

JAMES A. GOSMAN, M.D.,
Trustee

Eighth Trustee District

HOUSE ACTION: Approved.



DONALD R. TAYLOR, M.D.,
Trustee

The Delaware-Blackford County Medical Society hosted the annual meeting of the Eighth District Society at Delaware Country Club in Muncie on June 11, 1969. The meeting was chaired by Dr. Francis E. Stout, president, with the assistance of Dr. Richard Philbert, secretary-treasurer.

The activities and problems of the Indiana State Medical Association were discussed by the district trustee. He especially noted that there has been a marked decrease in AMA membership among the physicians of the district. This was explained by dissatisfaction with AMA policies and activities during the past year by the conservative membership of this area.

Mr. Herbert Dixon talked briefly on Blue Shield problems and programs during the past year and Mr. Jim Waggener reported on activities from the ISMA office.

Dr. Richard Ingram of Montpelier was elected as trustee to succeed Dr. Donald R. Taylor who has completed two terms as counselor and trustee as of October, 1969.

Following a social hour, dinner was served to about 65 members and guests. Dr. Jack Hickman, assistant dean of student affairs at Indiana University Medical School furnished a very interesting program. He was aided by four I.U. medical students who described the activities of the student council, of the Student American Medical Association, and of the Student Community Clinic which they staff in Indianapolis.

The 1970 meeting will be conducted by the Randolph County Medical Society in June, 1970. Dr. David J. Landon was elected president; Dr. Carol R. Chambers, secretary-treasurer and Dr. Richard Ingram, trustee.

DONALD R. TAYLOR, M.D.,
Trustee

Ninth Trustee District

HOUSE ACTION: Approved.



PETER R. PETRICH, M.D.,
Trustee

The annual meeting of the Ninth District Medical Society was held this year at Lafayette, Indiana, at the Lafayette Country Club, Tippecanoe county being the host society.

A very fine day was enjoyed by many of the physicians of the ninth district and the featured speaker of the evening was Representative Richard Roudebush.

During the past year I trust that the officers of the society have shared with their membership reports which have been forthcoming following the meetings of the Board of Trustees. It is urgent that all of us take an active part in the business of organized medicine and in the business of Indiana State Medical. The business of our society is your business and your business is our business. We will try our best to do everything that we can for you in the way of aids to your office, etc. We hope that we may enjoy your help from time to time when called upon. If you are contacted to serve on a commission or committee and it is at all possible for you to do so, please signify consent and cooperate by appearing at meetings and doing the part that you are given to do. It has been a pleasure to be with many of you during the past year, and I hope to see you all again through the next year.

PETER R. PETRICH, M.D.,
Trustee

Tenth Trustee District

HOUSE ACTION: Approved.



VINCENT J. SANTARE, M.D.,
Trustee

The Tenth District Medical Socicty had two successful meetings during the current year. The first meeting was held September 25, 1968 at the Red Lantern Inn, Beverly Shores, Indiana. Raymond J. Doherty, M.D., secretary of the tenth district society, presided at a dinner attended by 120 doctors and their wives. The minutes of the May meeting were approved as published in the *Bulletin of the Lake County Medical Society.*

Dr. Doherty introduced John Reed, M.D., president of the Porter County Medical Society; Peter Petrich, M.D., Councilor of the Ninth Medical District of the Indiana State Medical Association; Mr. Herbert P. Dixon, vice-president and physicians relations directer of Indiana Blue Shield; Mr. James A. Waggener, executive secretary of the Indiana State Medical Association; Mr. Howard Grindstaff, field secretary of the Indiana State Medical Association, and Lowell H. Steen, M.D., chairman of the Council of the Indiana State Medical Association.

Mrs. Lambro Dimitroff, president, woman's auxiliary, Lake County Medical Society, conducted a raffle of a money hat to raise funds to support the auxiliary programs. The raffle was won by Mr. Dixon who donated the money to a child sponsored by the Christian Children's Fund, living in Brazil. This money was given as a Christmas present to the child.

Dr. Doherty conducted an election of officers with the following individuals elected: Councilor, tenth district of the Indiana State Medical Association to succeed Lowell H. Steen, M.D., at the expiration of his term December 31, 1968—V. J. Santare, M.D., of Munster; alternate councilor—Tom Disney, M.D., of Gary, to complete the unexpired term of Herman Wing, M.D., who resigned because he had moved to Chicago; president of the Tenth District Medical Society—R. J. Doherty, M.D., of Merrillville; secretary of the Tenth District Medical Society, Lambro Dimitroff, M.D., of Calumet City, Illinois.

V. J. Santare, M.D., chairman of the Lake County Medical Society Committee on Governmental Programs, conducted a panel discussion on Comprehensive Health Planning. Other participants in this panel were Norman J. Wilson, M.D., president of the Inter-Agency Health Council; Mr. James A. Waggener, executive secretary of the Indiana State Medical Association, and Dr. Tom Sherrard, Director of Urban Development Institute of Purdue University.

On April 9, 1969, the spring meeting of the tenth district was again held at the Red Lantern Inn, Beverly Shores, Indiana. During dinner, Dr. Doherty, who presided at the meeting, presented Donald R. Taylor, M.D., chairman of the Board of Trustees of the Indiana State Medical Association; Malcolm O. Scamahorn, M.D., assistant treasurer of the Indiana State Medical Association; Mr. Howard Grindstaff, field secretary of the Indiana State Medical Association; Mr. Herbert P. Dixon, vice-president of Blue Shield of Indiana; V. J. Santare, M.D., tenth district trustee; and Lowell H. Steen, M.D., president-elect of Indiana State Medical Association. Thomas Tyrell, M.D., of Calumet City, Illinois was elected alternate trustee to the Indiana State Medical Association Board of Trustees. His term is to begin in October, 1969 at the organizational meeting of the Board of Trustees. An election was also held for the tenth district board member of the Blue Shield Board of Directors. Seymour W. Shapiro, M.D., of Merrillville was elected.

President-Elect of the Indiana State Medical Association, Lowell H. Steen, M.D., made a report on state association affairs, with particular emphasis on programs in continuing medical education, Medicaid, and the Conference of County Society Officers that was scheduled for April 12th and 13th, 1969 in Indianapolis.

The tenth district trustee of Indiana State Medical Association made a report on the recent activities of the State Association Board, with emphasis on Comprehensive Health Planning.

Ross L. Egger, M.D., the principal speaker for the meeting, who is regional advisor of the American Academy of General Practitioners Commission on Education, urged more active participation and discussed the reasons for the standards for certification by the new American Board of General Practice. He outlined the techniques of the examination to be given, which will certify general practitioners by this new board, and detailed at great length the long period of time that board certification for generalists had been under study.

In accordance with the usual, customary, and reasonable activities of the tenth district, we have had another active and productive year. We have taken pride in pioneering in the field of utilization review, and in continuing medical education on a district-wide basis. We continued to function with minority participation and hope that as time passes we will see further involvement by our sister counties in the district who progressively have become more viable and active in the past two years. We believe that the key to an active and functional state association is the vigorous participation of each district society in the affairs of ISMA, and in order to obtain participation on a wide and active basis, we urge and have worked toward the broadening of the base of activity by involving more individuals in committee function and by fragmentation of many of the large committees into more functional units.

VINCENT J. SANTARE, M.D.,
Trustee

Eleventh Trustee District

HOUSE ACTION: Approved.



LOWELL J. HILLIS, M.D.,
Trustee

The meeting of the Eleventh Trustee District in Delphi, Cass County, Indiana, was on September 18, 1968. The activities in this area have been largely confined to local county activities.

At the meeting in Delphi, Dr. John Jarrett of Grant County was elected the president, and Dr. Fred Poehler of Wabash County was elected secretary-treasurer. Dr. James Harshman was re-elected alternate to the Board of Trustees of the Indiana State Medical Association.

The next meeting of this district will be held in Marion, Indiana, September 17, 1969. The meeting will be held at Emily's Restaurant, and the program is being arranged by Dr. Eugene Rifner.

The county activities in this district have been mainly those associated with comprehensive health planning. Howard County and Grant County have made great strides in comprehensive health planning under the leadership of Drs. James Harshman and Lester Renbarger. Cass County is in the final stages of completing its comprehensive health plan, and Miami and Wabash Counties are working in this field.

Notice will be made of the activities of the County Board of Health in Carroll County, under the direction of Dr. T. Neal Petry and Dr. C. L. Wise, in cooperation with the other members of the Carroll County Medical Society, this organization has become a model in the functioning of a county board of health in cooperation with the county medical society and their work has progressed nicely.

The Miami County Society and the Wabash County Society have been fortunate in the progress they have been able to make in their clinical laboratory and radiological departments. These departments now enjoy some of the most advanced diagnostic procedures in the state.

Very little work has been done in the area of emergency medical services. The formation of the Emergency Medical Services Commission has resulted in awaiting the results of the "trailblazing," and other procedures that are being done in Allen County. When these procedures have been tested, they will undoubtedly be carried on in these contiguous counties.

Your trustee has attended several fine meetings, especially in Wabash County and Miami County. Another fine meeting is to be held in Wabash County before our next district meeting.

Most of the activities in this district may be described as "business as usual."

LOWELL J. HILLIS, M.D.,
Trustee

Twelfth Trustee District

HOUSE ACTION: Approved.



WILLIAM R. CLARK, SR., M.D.,
Trustee

Last year I reported that the Twelfth District had started undergoing reorganization. The purpose of the reorganization was to improve the communication between the trustee, the county officers and each individual member of the Twelfth District. I had hoped that I could create a better understanding of the problems that confront organized medicine today. I hoped that more interest could be stimulated in getting more M.D.'s (both young and old) in the future destiny of organized medicine. I hoped and asked for the cooperation of the members and the officers so that I could better represent them at the state level; thereby making it possible to coordinate the activities of the district with the Indiana State Medical Association in improving our own image and better patient care.

We have come a long way by adopting a Constitution and Bylaws. This document has set up a board of directors comprising all county officers, Indiana State Medical Association delegates from the Twelfth District and the district officers. The board meets four times a year. It has been quite successful in starting and carrying out the ideas outlined in the first paragraph of this report. There is still much work to be done so that (with all counties working together) the Twelfth District will become a unified force in developing the purpose of our organization as outlined in our new Constitution and Bylaws.

Our annual meeting was held on May 21st at the Club Olympia, Fort Wayne, Indiana. The meeting was well attended and the following guests were present:

Ralph Everly, M.D., chairman of the Executive Committee of the ISMA; Burton Kintner, M.D., member of the Executive Committee of the ISMA; Malcolm Scamahorn, M.D., assistant treasurer of the ISMA; Donald Taylor, M.D., Eighth District trustee and chairman of the board; Peter Petrich, M|.D., Ninth District trustee; John Butler, M.D., Seventh District alternate; Otis Bowen, M.D., Thirteenth District trustee; Mr. James Waggener, executive secretary of the ISMA and Mr. Howard Grindstaff, field secretary of the ISMA.

Dr. Kenneth Isenogle, president of the Twelfth District, presided. New officers named were John Hartman, M.D., Angola, president; Robert Edwards, M.D., Auburn, vice-president; DeWayne Hull, M.D., Fort Wayne, secretary-treasurer and Kenneth Isenogle, M.D., Fort Wayne, elected to fill the unexpired term of Dr. Mahlon Miller on the Blue Shield board.

The new Constitution and Bylaws was adopted after several changes were made in the original that had been drafted by the officers and board of directors. Reports were given by the officers and a typewritten report of my activities, as well as future plans for the association as trustee, was made available to all in attendance.

That evening we were treated to a panel discussion on the subject, "Indiana Medicaid—Friend or Foe?"

The panel participants were Eugene Senseny, M.D., state delegate to the American Medical Association, acting as moderator; Otis Bowen, M.D., Thirteenth District trustee and Speaker of the House of Representatives of the Indiana State Legislature; Floyd Coleman, M.D., state representative from DeKalb County and Mr. William Sterrett, administrator of the Indiana Department of Public Welfare.

This was a very informative discussion and was much appreciated by all. My thanks to those participating.

I also want to thank the out-going officers for their leadership and co-operation during the past year. I want to express my deep appreciation to Dr. Fred Schoen, my alternate. His wise counsel has been a great aid to me. (P.S. Fred has never missed a meeting.)

Along with the officers of the district, I look forward to the challenges of the new year. With their help and that of our new board of directors, I am sure the Twelfth District can and will successfully meet the challenges of the rapidly changing times in the practice of medicine.

WILLIAM R. CLARK, SR., M.D.,
Trustee

Thirteenth Trustee District

HOUSE ACTION: Approved.



OTIS R. BOWEN, M.D.,
Trustee

The annual meeting of the Thirteenth District Medical Society of Indiana is scheduled for Sept. 17th, 1969. It is in the planning stage at present. By the time this report is published and read, the meeting will already have been held; therefore no further comments concerning it are indicated.

The most important item to report concerns the status of comprehensive health planning in the Thirteenth District. All counties are either organized and functioning as a county unit in a proposed region, are part of a proposed region but without a county organization, or are part of a region and are forming a county organization in addition.

LaPorte, St. Joseph and Kosciusko counties are each organized as a county and are functioning in a proposed region; Starke and Marshall counties are part of a proposed region but without a county organization; and Fulton and Pulaski counties are part of a proposed region and are forming their own county organization.

During the past year there were five doctors in the district whose dues were remitted because of illness or retirement from practice or because of service in missionary work with each of these reasons causing hardship on the individual doctor.

OTIS R. BOWEN, M.D., *Trustee*

Editor of The Journal

HOUSE ACTION: Approved.

The Journal is experiencing another good year. All functions, with the possible exception of financial, are in good order.

Advertising revenue has been less than expected, but the size of each issue has been adjusted to compensate for this. Expenditures for items other than printing have been minimized. At the end of the first nine months of the fiscal year, we had a small positive dollar balance, before taxes.

The indeterminate element in the finances this year is the federal advertising revenue tax. The Internal Revenue Service has ruled that the sale of advertising space by a publication of a tax-exempt organization is a transaction which is unrelated to the purposes for which the organization is granted its tax-exempt status and that the revenue from such sale is subject to taxation.

Certain expenses of selling, processing and publishing the advertising may be deducted from the gross revenue to determine the net amount which is taxable. At the time of this writing the association has not been able to obtain a legal opinion in regard to the method of determining the taxable net amount, and cannot predict what the tax obligation will be.

It is possible that our total advertising income for the fiscal year will equal or approach that for last year. The first half of the year was down by some 25% but this summer has been the best ever and may cure the shortage accumulated during the winter months.

The scientific content of *The Journal* has been supported admirably by a large number of short and practical articles of clinical importance. Authoritative review and original essays have been contributed by members of the faculty of Indiana University School of Medicine and the Krannert Institute of Cardiology.

Special articles on the Heart, Cancer, and Stroke Program, Comprehensive Health Planning, and Medicaid have been included for the information of the profession.

FRANK B. RAMSEY, M.D.,
Editor

Delegates to AMA

HOUSE ACTION: Accepted for information.

Delegates to an AMA convention have never been busier than they were at the 118th Annual Convention in New York July 13 through 17.

During 15 hours and 40 minutes the House was in session, not including the inaugural ceremony, delegates heard a 20-minute speech by the Vice President of the United States; heard a 25-minute informal address by the newly appointed Secretary of HEW for Health and Scientific Affairs; heard the final report of President Dwight L. Wilbur; presented a special award to the medical staff of NASA's Manned Spacecraft Center in Houston; listened to reports from AMPAC, AMA-ERF and SAMA; roundly applauded President Gerald D. Dorman Thursday morning for not delivering his first report to the House, but instead distributing it for delegates to read; and still found time to act on an all-time record of 196 items of business—an average, even with everything else going on, of one vote every four minutes and 47 seconds.

Business presented to the House included 59 reports from the board of trustees; the executive vice president; and standing and special committees; and 137 resolutions, four of which were memorials and one a commendation of President Wilbur.

Of the 59 reports, the House adopted 30; adopted and referred one; amended and adopted five; approved 17; and accepted two for information. Four required no House action.

Of the 137 resolutions, 17 were adopted; 28 were adopted as amended or a substitute was adopted; 30 were referred, with or without amendment; 44 were combined with one or more other resolutions before action was taken; one was partially adopted and partially referred; 15 were rejected; and two were withdrawn.

Elections

After a nominating speech and seconds by 18 delegates, Walter C. Bornemeier, Ill., was elected president-elect by acclamation. He will become the AMA's 125th president at the Annual Convention of 1970 in Chicago.

The House unanimously elected M. Louise Gloeckner, Pa., as vice president; and Russell B. Roth, Pa., as speaker of the house.

J. Frank Walker, Ga., was elected vice speaker of the house.

In the election of trustees, Burt L. Davis, Calif.; Burtis E. Montgomery, Ill.; and Max H. Parrott, Ore., were unanimously re-elected. Charles A. Hoffman, W. Va., was elected to the trustee position vacated by Edward R. Annis, Fla.

Election to councils was as follows:

Constitution and Bylaws: Robert M. Tenery, Tex.

Medical Education: Joseph M. White, Tex., and William A. Sodeman, Pa.

Medical Service: John M. Rumsey, Calif., Richard E. Palmer, Va., and Donald R. Hayes, Mass.

Judicial Council: Charles C. Smeltzer, Tenn.

Vice President's Address

Vice President Spiro T. Agnew began his remarks with some very nice words about the medical profession.

"I can sympathize with those of you who, after struggling for years to improve the health of this nation, now find few kind words written and few voices raised in your defense.

"I believe that your record speaks for itself. I think that millions of Americans who appreciate their family doctors and

value the doctor-patient relationship know your work.

"So many opinion leaders nit-pick against the profession which, in this century, added more than 20 years to life expectancy; a profession which has virtually eliminated so many fatal, crippling and debilitating diseases in this country and around the world.

"Our medical profession has achieved this," he said, "not our politicians and not our press. And we betray every doctor, in and out of the AMA, when we deprecate your dedication."

The theme of Mr. Agnew's speech was pollution. "While enlightened man refuses to accept disease, he tolerates the erosion of his environment. Intelligent Americans who will not live in unpleasant surroundings among hostile people, endure with bland indifference mildly poisoned air, polluted waters and noise just below the pitch of madness. A nation capable of catapulting men to the moon is in mortal danger of devouring its irreplaceable, life-sustaining elements."

He described a number of anti-pollution programs being undertaken or planned by the federal government, in cooperation with the states and the private sector, and emphasized that "Private professional organizations like the AMA will have a role to play in encouraging environmental improvement. Your increasing voluntary participation at the state and local level can result in greater public support to enlarged programs."

He ended by saying, "We feel we act upon a mandate as fundamental as the problem itself. It's the first mandate of humanity: the right to survive."

Dr. Egeberg's Remarks

Dr. Roger O. Egeberg, Assistant Secretary of HEW for Health and Scientific Affairs, talked about the rising cost of health care, advances in medical science and the fact that physicians are working long, hard hours. "However," he said, "I don't want to sound soft on doctors. I don't want to sound soft on organized medicine. I do feel that there has been a principle that has been ignored perhaps more by organized medicine than it should be. And it comes, I think, from the ethics of Hippocrates, who preached that you should take care of those who came to you; those within your purview.

"I would think that is probably a very good ethic to follow. But we have to add something to it. And that is the ethic that as a group we must look around. We must see that there are people not in front of us who need help.

"The poor live utterly differently from us. But we have created a distribution of medical care in a way that suits us and suits the middle class.

"Now, in order to reach [the poor], we've got to find new ways of distributing medical care."

After some elaboration on those points, he closed by saying, "I would hope that the government will be able to cooperate with the people who are delivering the medical care; will take them into confidence; will discuss the solution of the problems. Because we have come to a crisis. We have to solve it. The more heads we can get at it, the more feeling of 'this is our problem' will exist. And if we can feel that it is our problem, rather than 'theirs,' I think we can solve it."

President's Final Report

In his report to the opening session of the House, President Wilbur said that physicians must have clinical sense, social sense and common sense.

Under clinical sense, he predicted that the greatest scientific advances will be in three areas: "Understanding and perhaps partial control of degenerative diseases; a substantial gain in knowledge and control of psychiatric disorders; and the control of reproduction, with better human and medical understanding of contraception, abortion, population control and control of those genetic characteristics to be most valued by humanity."

Under social sense, he asked, "Will we ever see a lessening of public interest in medicine and health? Will voluntary health agencies, social and welfare groups, planning bodies in the health field and public health groups lessen their great and growing interest in the development and application of knowledge in health or in medicine? Today, and even more in the future, health and medicine are not matters just for physicians and patients. They are matters of total public concern."

In this part of his talk, he discussed the removal of barriers to medical care and the need for more ambulatory care of patients, emphasizing the potential value of community health centers.

In the final section, he pointed out that "Tempering our clinical sense with a social sense is good common sense. It will be so recognized by the public.

"Changes in medicine and medical care," he said, "will best be made by evolutionary rather than revolutionary and disruptive change, aside from the rare, great discovery or invention in medical science."

He concluded with these words: "We can meet the health needs of the American people but we cannot meet them alone. While our knowledge of health may be unique and indispensable, our desire to serve all of society is matched by many of its other elements. We must lead, but our leadership must continually be earned. It cannot be assumed.

"As we look to the future, we must constantly ask ourselves the right questions and try to find the right answers — answers based, as often as possible, on fact and experience and tempered to the needs of people in a rapidly changing society."

Inaugural Address

After taking the oath of office as the 124th President of the AMA, Gerald D. Dorman listed three goals "which our House of Delegates has accepted on the road to our main objective, the best possible health care to all our patients who need it.

"One, a constantly advancing health care system in America. Two, a widespread respect for the leadership, and a widespread recognition of the contributions of the medical profession. And three, enhanced functioning of the medical profession."

The first goal, he said, must be "based on incentives and freedom of opportunity. Incentives are needed for people to stay healthy, for physicians, hospitals and allied professionals to increase care and hold down costs."

As to the second, he said, "We know that it is in the best interests of the nation's people that physicians maintain and strengthen their leadership in all matters pertaining to health care. To do so, however, we must perform at a height beyond any level achieved before.

"We must, besides earning the position of leadership, be worthy of the respect that goes with it. The profession must be above all suspicion. This means that we must maintain a visible sincerity and dedication in our profession."

About the third, "I would mention enhancement of the functioning of the medical profession by more effective communication within the profession, with the allied health professions, with influential groups of our citizenry, educators, clergy, business men, labor, lawyers, civic leaders and leaders of government on all levels."

He concluded by stating that "The problems that exist in medical and health care for the people of our nation will not be solved overnight. Nor will they be solved in a month or a year. But solutions—at least, proposals and experiments to find solutions—will be forthcoming."

First Report to the House

Because of the volume of business and the shortage of time on the final day of the convention, President Dorman announced to the House that he would not deliver his first report. Instead, copies were made available to the delegates to read at their leisure.

In the report, Dr. Dorman pointed out that the physician has distinct advantages in the satisfaction he gets from his profession, and the honor in which he is held by other people. He also pointed out that as the penalty of professionalism, "we must willingly accept not only the respect it brings us, but also the obligation to be deeply and actively concerned with every facet of health and health care. There is no aspect of health, direct or remote, that is not our responsibility, in whole or in part."

He then listed problems and showed what the AMA is doing about them now and suggested other things that might be done. Included were quality of medical care; physicians who cheat on government financing programs; providing care, for the poor; sex education; maternal and child care; and methods of delivering medical and health care.

All of those problems, "as health matters, require action. All of them, as health problems, demand solutions. I am confident the solutions will come and that they will come—principally through the deliberations and the programs of the American Medical Association and all of the medical profession and its allies. We cannot delay. We must meet the demanding obligations which are the penalty of our leadership in medical and health care."

ACTIONS OF THE HOUSE OF DELEGATES

As a matter of convenience, actions taken by the House will be listed here in the order in which they were presented to the House by the various Reference Committees.

Reference Committee on Amendments to Constitution and Bylaws

AMA Membership for Osteopaths: In response to a House directive at the Clinical Convention, 1968, that qualified osteopaths be admitted to full active membership in the AMA, the House amended the first paragraph of Chapter I, Section 1 of the Bylaws as follows:

> (A) Regular Members—Regular membership shall be limited to those members of a state medical association who hold the degree of Doctor of Medicine or Bachelor of Medicine, or who hold an unrestricted license to practice medicine and surgery, and are entitled to exercise the rights of membership in their state medical associations, including the right to vote and hold office, as determined by their state medical associations.

Scientific Sections: The Ad Hoc Committee to Study the Modus Operandi of the Scientific Sections reported its belief (which the House adopted) that the AMA can achieve greater unity within the medical profession and further strengthen its scientific program by inviting the national medical specialty societies to play a more active and responsible role and giving those societies a privilege of participating in the selection of section delegates in the AMA House and other section officers.

The scientific assembly will be divided into these specialty sections:

Allergy
Anesthesiology
Clinical Pharmacology and Therapeutics (formerly Experimental Medicine and Therapeutics)
Colon and Rectal Surgery
Dermatology
Diseases of the Chest
Family and General Practice (formerly General Practice)
Gastroenterology
General Surgery
Internal Medicine
Military Medicine
Obstetrics and Gynecology
Ophthalmology
Orthopedic Surgery
Otorhinolaryngology
Pathology (formerly Pathology and Physiology)
Pediatrics
Physical Medicine and Rehabilitation (formerly Physical Medicine)
Preventive Medicine
Psychiatry and Neurology (formerly Nervous and Mental Diseases)
Radiology
Special Topics
Urology

AMA Bylaws, Chapter VII, Sections 3-9, are to be rewritten to effect these changes, among others:

Each section will establish a section council. After the 1970 Clinical Convention, medical specialty societies will be invited to help form section councils.

Membership of the section councils "shall be selected by the national specialty societies listed in the American Medical Directory apportioned on the basis of the number of AMA members belonging to each specialty society and one member to be elected by the scientific section from the section membership."

At the 1971 Annual Convention, establishment of AMA section councils will be reported to each specialty section. The councils become effective January 1, 1972. All section councils will be under the direction of the Board of Trustees and will be governed by rules established by the Board and approved by the House.

Reference Committee A

Cost of Care: The House stated that "The physician's influence on the costs of health care will be in proportion to his conscious efforts to adhere to practices which conserve the resources of his patient. As the provider of medical service, the doctor has a significant and responsible role in any organized effort to control health care expenditures. In this role, the physician has a challenge to maintain and improve a system that best serves the public and is most acceptable to him and to the profession of which he is a part."

Medicare and Medicaid: In connection with reducing medicaid costs, the House adopted a report listing four action programs of the profession: expanded peer review programs by county medical societies to reduce hospital and nursing home care and to expand ambulatory care; eradication by the profession of isolated abuses by physicians; promotion of innovative health service delivery systems for low income communities, with emphasis on ambulatory care; and programs by local medical societies to preserve quality of care in the face of cost containment measures.

With respect to physician payment in teaching situations, the House resolved that the Board of Trustees "take action to evaluate and effect improvement of the regulations in keeping with the intent of Medicare and Medicaid in relation to teaching situations."

On the subject of medicare fees and fee schedules, the House said, "While the AMA has not taken a specific position on the procedures relating to the development and application of physicians' fees profiles and prevailing charge screens, the actions which have been taken by the House would indicate that these concepts as defined through directives of the Social Security Administration, are not consistent with policies of the American Medical Association."

The House also said that since "Actions taken by DHEW to set rigid limits on levels of payments to physicians who provide services under Medicaid appear in contradiction to Congressional intent that Medicaid patients receive care on the same basis

as private patients," it resolved that the AMA "urge a reassessment by Congress of its intent and priorities in relation to Title XIX."

Regarding the isolated abuses of government programs, the House resolved that the Board's "efforts to obtain access to information referable to alleged misuse of any programs of health care be commended" but added that "In the publicizing of charges without the availability of reasonable and specific facts concerning individuals, the result is detrimental to the best interests of American medicine."

Voluntary Health Insurance: The House adopted a report urging that state medical association county societies and physicians individually direct "unstinting effort" to promote the proposed program of income tax credits for financing health care and "publicize the advantages inherent in this approach to preserve and strengthen the voluntary system."

Delegates also resolved that the AMA "encourages the development of prepayment medical insurance programs in which the payment to the physician is based upon the usual, customary or reasonable fee concept" and that "any reference to 'paid-in-full' coverage clearly identify those services which are indeed covered on a 'paid-in-full' basis and also identify the circumstances under which those services must be rendered."

Billing Procedures: "To ensure the continuance of the one-to-one physician-patient relationship," the House stated, "the profession considers direct billing preferable—identifying Medicare primarily as a financial aid to the patient. As long as Medicare holds to a realistic assessment of 'reasonable charges,' there will be comparatively few instances when direct billing entails greater out-of-pocket payment by the patient than does assignment."

Peer Review: This statement was adopted by the House: "The Council on Medical Service knows of no greater challenge facing the profession today than to secure universal acceptance and application of the peer review concept as the most meaningful method for creating a public awareness of medicine's efforts to assure high quality of health services at a reasonable cost."

Comprehensive Health Planning: The House said, about comprehensive health planning, that "Certainly, physicians and their professional organizations must accept the responsibility of working in the planning group throughout all stages of planning in order to provide guidance in choosing goals and programs that will realistically meet the community's needs;" and further resolved that "financial reimbursement for health care be based on the adequacy, competency and efficiency of patient care and not on the basis of approval by any regional planning agency."

Reference Committee B

Medical Care as a Right: To make its position clear in the long-standing discussions of medical care as a right, the House resolved that it "reaffirm its position (1) that it is a basic right of every citizen to have available to him adequate health care; (2) that it is a basic right of every citizen to have a free choice of physician and institution in the obtaining of medical care; and (3) that the medical profession, using all means at its disposal, should endeavor to make good medical care available to each person."

Government Reports: The House resolved that "the American Medical Association make every effort to secure appropriate payment to physicians for complex and detailed reports prepared for use by governmental agencies." This resolution does not affect the 1965 Judicial Council opinion that simplified insurance forms be completed without charge.

Extended Care: Because of the higher cost of hospitalization, the House resolved that the AMA "be urged to seek changes in the medicare law to allow direct admission to extended care facilities when edigible patients' conditions require less than acute hospital care."

Reducing Paper Work: Recognizing the avalanche of paper that threatens to inundate physicians, the House resolved that the AMA and state medical associations "undertake new discussions with governmental agencies, insurance companies and hospitals with the objective of achieving substantial reductions in the amount of paper work—hopefully amounting to at least a one-half decrease—and thus reducing the cost of health care and enabling physicians to devote the maximum time and effort possible to the care of patients."

Reference Committee C

Private Practice: A resolution that the AMA "establish a Council on Private Practice, with the primary objective being to espouse the aspirations and goals of private practice" was adopted by the House and referred to an ad hoc committee to be appointed by the speaker of the house.

Federal Support of Medical Schools: In a change of House policy regarding federal loans to medical students, a joint report of the Board of Trustees and the Council on Medical Education was approved which calls for an increase in financial support of medical schools by the federal government to permit a major increase in the enrollment of medical students and the production of physicians. The change was considered justified because of current fiscal conditions which make it increasingly difficult for students to obtain loans from the private sector as a result of high interest rates and a restricted supply of money for personal loans.

Relicensure: The House approved a report recommending that "the physician's continued competency to provide quality health services be maintained by every practical means available; that a relicensure program not be considered at this time; that peer group evaluation be continually utilized and improved; that methods of improving the availability and the content of continuing education programs be continually investigated and refined; that additional incentives be positive in nature and come from within the profession."

Educational "Essentials": The House approved essentials of an accredited educational program in nuclear medical technology; revision of essentials of approved residencies in thoracic surgery, neurology, anesthesiology and general requirements; revision of essentials of approved internship to provide for participation of osteopaths; revision of essentials of approved residencies pertaining to osteopaths; and essentials of an accredited educational program for medical assistants.

Reference Committee D

Health Care of the Poor: The House adopted the report of the Board of Trustees' Committee on Health Care of the Poor, which reiterated "our strong commitment toward expanding nationwide programs to improve the health of the poor" and stated that "the same quality of medical care should be accessible to all people."

The committee listed "certain concepts that we believe must be included in the association's program:" (Paraphrased and condensed.)

1. Providing comprehensive health care to the poor is a desirable goal.
2. It must be a continuing program, identifying both short-range and long-range activities.
3. The committee's purpose must be to implement the research that has been done on unmet needs for health services.
4. Program must provide for participation of the poor in planning projects for their communities.
5. Physicians should work with numerous

other organizations, both in and out of the health field, that have expressed concern about improving health care of the poor.

The committee concluded by stating that it "recognizes that the problems for which it hopes to find solutions are too critical and too complex for superficial, cursory answers. It believes that dynamic action in this field must have a top priority in the American Medical Association's activities."

Physicians and Hospitals: Most items considered by this Reference Committee had to do with physicians, hospitals and the JCAH.

For example, the House resolved that "the AMA Commissioners to the JCAH urge the joint commission to insure that that body which carries out the governing function of the medical staff shall be representative of the medical staff, both hospital-based and voluntary, and that this body shall advise the governing board of the hospital on policy regarding medical judgment and skill and on matters relating to the bylaws, rules and regulations of the medical staff."

The House also resolved that the AMA urge the JCAH "to give approval to effective staff and section meeting structures which combine two or more hospitals with overlapping medical staffs within a logical geographical area."

Reference Committee E

Full Disclosure of Laboratory Billings: The House adopted a Judicial Council report, "Review of Ethical Considerations Relating to Clinical Laboratories," which ended with this paragraph: "Where it is necessary for the attending physician to bill his patient for services performed by a clinical laboratory, the bill submitted by the attending physician to his patient should state the name of the clinical laboratory performing the services for his patient and state the exact amount of the laboratory charge paid or to be paid by the physician to the clinical laboratory."

Also adopted was the resolution that the "attending physician is entitled to fair compensation for the professional services he renders. He is not engaged in a commercial enterprise, however, and any markup, commission or profit on the services rendered by a laboratory is exploitation of the patient."

Blood Donors: The House encouraged "state medical associations to actively promote state legislation to provide that persons age 18 or over may donate blood without the necessity of parental permission or authorization and without restriction to voluntary or non-compensatory blood donation programs."

Prescription Labeling: Two resolutions concerning the labeling of prescriptions were referred to the Board of Trustees and the Council on Legislative Activities, after being adopted by the House. One recommends legislation requiring labeling; the other encourages labeling.

Reference Committee F

Financial Report: The AMA's financial statement for the year ending June 30, 1969, was approved and the House then resolved that "the Finance Committee of the Board of Trustees meet in advance of each annual convention with the Reference Committee to which the annual financial statement will be referred for presentation and discussion of more detailed budget and financial data of the association, so that the Reference Committee will be able to make a more meaningful evaluation for the House of Delegates."

AMA Management Survey: The House adopted the management survey report of Cresap, McCormick and Paget and approved the analysis of communications made by the Philip Lesly Company.

In connection with the former, the House approved the Reference Committee's list of eight subjects to which "the highest priorities in activities and programs should be assigned:"

1. The rising cost of health care.
2. The expansion of out-of-hospital health services.
3. The development of community health centers.
4. Experimentation and innovation on new methods of delivery of health services.
5. Medical audit, utilization and review committees.
6. Medical manpower needs.
7. Preventive medicine.
8. Family planning.

The House also requested that the Board of Trustees (1) develop program priorities; (2) outline specific techniques of resolving the problems caused by those priority programs; and (3) report to the House at each semi-annual session on progress being made.

State Projects of AMA: The House resolved that "financial support by the AMA for local or area health service projects should be preceded by consultation with the constituent association of the state or states in which the projects are to be conducted."

Professional Liability: In connection with professional liability, the House adopted the following statements as recommendations of the AMA:

1. First, that constituent associations "seek the enactment of appropriate state legislation designed to provide a more efficient and equitable determination of malpractice claims and litigation."

2. Second, that state associations, with the help of AMA, "seek the cooperation of hospital associations and third party payers in exploring and developing, if feasible, pilot programs which will provide scheduled benefits for persons injured as a consequence of medical accidents occurring in the delivery of health care, irrespective of fault."

3. Third, "that workshops on malpractice insurance problems be conducted, as requested by the Board of Trustees, in which participation will be invited from (1) physicians confronted by insurance problems, (2) representatives of the insurance carriers, (3) staff attorneys of AMA and other appropriate staff personnel, (4) representatives of and attorneys for the hospital service field, (5) nurses and (6) legislators."

In addition, the House resolved that the AMA "should not attempt to establish a nationwide professional liability insurance program either by sponsorship of a program underwritten by an existing insurance carrier or by seeking to establish a new insurance carrier."

Reference Committee G

Sex Education: While recognizing "that the primary responsibility for family life education is in the home," the House supported "in principle the inauguration by State Boards of Education or school districts, whichever is applicable, of a voluntary family life and sex education program at appropriate grade levels:

"(1) as part of an overall health education program;

"(2) presented in a manner commensurate with the maturation level of the student;

"(3) following a professionally developed curriculum foreviewed by representative parents;

"(4) including ample and continuing involvement of parents and other concerned members of the community;

"(5) developed around a system of values defined and delineated by representatives comprising physicians, educators, the clergy and other appropriate groups; and

"(6) utilizing classroom teachers and other professionals who have an aptitude for working with young people and who have received special training."

Nursing: The House reaffirmed "its support of all forms of nursing education including baccalaureate, diploma, associate and practical nurse education pro-

grams" and encouraged "the continuation of federal, state and local subsidies to schools of nursing education."

Smoking and Health: The House resolved that the AMA "again urge its members to play a major role against cigarette smoking by personal example and by advice regarding the health hazards of smoking" and "discourage smoking by means of public pronouncements and educational programs." It also resolved to "indicate to the Congress of the United States the incongruity of the expenditure of tax dollars to promote the production and sale of tobacco while at the same time spending other tax dollars to discourage cigarette smoking because of its hazard to health."

Food Mixes: The House requested the U.S. Food and Drug Administration to "favorably consider the proposal of the Council on Foods and Nutrition regarding labeling of fatty-acid composition" of food mixes, and that the Council on Foods and Nutrition "undertake the development of a rational proposal for identifying and labeling other nutritionally significant components of convenience foods."

Protective Headgear: The Committee on the Medical Aspects of Sports was asked by the House "to continue its efforts to utilize and publicize existing research and recommendations on football helmets to assure optimum protection for players against impacts which cause head and neck injuries" and "to do everything possible to discourage the practice of 'spearing.'"

Reference Committee H

Highway Signs: A Board of Trustees report and a resolution were adopted recommending a uniform system of highway directional signs designating emergency medical facilities. However, the House pointed out clearly that "this action does not encourage or approve the use of the copyrighted AMA symbol for other unauthorized and unidentified programs."

Credit Cards: Two resolutions concerning the use of credit cards to pay for medical care were referred to the Judicial Council for information, "with the expectation that additional opinions will be rendered as experience accumulates." In certain states, the Reference Committee pointed out, a charge card system is under experimentation by the state medical society and is deserving of a chance to prove its merits. Also, the Judicial Council has ruled that the use of a charge card system should be flexible and at the discretion of the individual state medical societies.

Medical Instruments and Devices: Pointing out that legislation related to federal standards to regulate the use of medical instruments and devices was introduced in the 90th and 91st Congresses, the House resolved that the AMA "be commended for its position supporting the concept of a thorough study of the field of medical instruments and devices prior to passage of specific regulatory legislation."

Unification Through AMA: The House resolved that the Board of Trustees be asked to begin a study "of physicians who are not members of the AMA, and then make recommendations to the House of Delegates and to the state and county societies, as to how the medical profession may more wisely unify itself under the AMA banner, and encourage non-participating physicians to join."

Presentations, Awards and Announcements

Robert E. Gross, M.D., was presented the Dr. Rodman E. Sheen and Thomas G. Sheen Award. Dr. Gross is Ladd Professor of Children's Surgery at Harvard Medical School and director of cardiovascular surgery at Children's Hospital Medical Center, Boston.

Charles A. Berry, M.D., medical director of the NASA Manned Spacecraft Center in Houston, was presented a plaque: "The American Medical Association presents this citation for distinguished service to medicine to Charles A. Berry, M.D., and the medical staff of the Manned Spacecraft Center, NASA, at Houston, Texas, in recognition of their efforts in solving the difficult and complex problems of assuring the health and contributing substantially to the safety and survival of the astronauts participating in the United States space exploration program."

Stephan R. Chernay, M.D., New York, received the first AMA recognition award for continuing education.

Executive Vice President E. B. Howard announced to the House the appointment of Richard Wilbur, M.D., Calif., as Assistant Executive Vice President of the AMA. An Assistant Executive Vice President for Scientific Affairs also is to be named.

The medical winners in the 20th International Science Fair for high school students were introduced to the House and their exhibits were included among the scientific exhibits at the convention.

They were Cathy Jennemann, 16, a junior at Monte Cassino High School, Tulsa, Okla., whose exhibit was "Possible Deafness From Everyday Noise;" and Greg Kauffman, 16, a junior at Albuquerque (N. M.) High School, "Pyelonephritic Recurrence."

Interruption

The House suffered a 21-minute interruption during its opening session Sunday when 30 to 40 dissident medical students and their friends, many with beards, some wearing white smocks, seized the podium and demanded the right to address the House.

The news release they distributed identified them as representatives of the Student Health Organization, the Medical Committee for Human Rights, the Movement for a Democratic Society, the Health Policy Advisory Center, the Rockefeller University Committee for a Democratic Society "and many others."

The group's spokesman began by declaring the meeting "illegal and illegitimate" and ended by burning what he called his AMA membership card, but which television news described as a Blue Shield card.

He came back Wednesday with a "non-negotiable demand" for 10 minutes to speak during the inaugural ceremony, but was flatly refused by the Reference Commitee on Rules and Order of Business.

GUY A. OWSLEY, M.D.
JACK E. SHIELDS, M.D.
DON E. WOOD, M.D.
EUGENE F. SENSENY, M.D.
FRANK H. GREEN, M.D.

Report of Board of Medical Registration and Examination of Indiana (July 1, 1968 to June 30, 1969)

HOUSE ACTION: Ordered filed.

Applications received for June, 1969, state board examination (medicine)	452
Ineligible to take state board examination for various reasons	32
Approved for 1969 state board examination	420
Failed to appear for state board examination	56
Applicants taking state board examination	364
Candidates who failed the state board examination	107
Candidates who failed in one subject only (included in above)	0
Candidates from Indiana University Medical School taking state board examination	178
Candidates from Indiana University Medical School taking state board who failed	4
Candidates from other American medical schools taking state board examination	4
Candidates from other American medical schools who failed	0
Candidates from foreign medical schools taking state board examination	182

Candidates from foreign medical schools who failed	103
Over-all failure rate	29%
I.U.M.C. graduate, failure rate	2½%
Other American school graduate, failure rate	0%
Foreign medical school graduate, failure rate	56%
Candidates taking chiropractic state board examination	0
Candidates taking physical therapy examination	31
Candidates taking physical therapy examination who failed	0
Candidates taking podiatry state board examination	1
Candidates taking podiatry national board examination, licensed	3
Candidates in podiatry who failed	0

TOTALS, LICENSED BY EXAMINATION

	1966-1967	1967-1968	1968-1969
Medicine	303	330	257
Physical therapy	3	29	31
Podiatry	3	3	4
Osteopathy	0	0	0
Chiropractic	0	0	0

(The change in number of licensees by examination in medicine is due to radical change in examination).

	1966-1967	1967-1968	1968-1969
Applicants granted license in Indiana by endorsement/ reciprocity (M.D.)	170	163	135
Applicants endorsed to other states (M.D.)	224	342	315
Applicants granted license in Indiana by endorsement/reciprocity (osteopathy)	14	10	11
Applicants endorsed to other states (osteopathy)	0	0	2
Applicants granted physical therapy license in Indiana by endorsement/reciprocity	26	21	30
Physical therapists endorsed to other states	1	1	7
Applicants granted chiropractic license in Indiana by endorsement/reciprocity	26	14	13
Chiropractors endorsed to other states	1	0	0
Applicants granted podiatry license in Indiana by endorsement/ reciprocity	0	0	3
Podiatrists endorsed to other states	0	0	1
Citations or board action during the year (all groups)	0	12	0
Revocations during the year (all groups)	0	2	0
Licenses reinstated	0	2	2
Physicians voluntarily surrendering their Narcotic Stamp to the Internal Revenue Department	0	6	6

TOTALS, BOARD LICENSURE:

	1966-1967	1967-1968	1968-1969
7,655 (M.D.) (resident and non-resident)	7,012	7,165	7,655
279 (D.O.) (resident and non-resident)	261	271	279
180 (Drugless) (resident and non-resident)	212	205	180
343 (Chiropractors) (resident and non-resident)	342	369	343
316 (Physical therapy)	269	292	316
198 (Podiatry)	201	203	198
2 (Midwife)	1	2	2
Temporary physical therapy permits issued	3	5	7
Temporary medical permits issued	25	37	56
Internship permits issued	78	164	156
Temporary medical educational permits issued	2	54	50
Temporary physicians permits issued	0	0	32
Medical teaching permits issued	0	0	9
Medical corporations licensed in Indiana	0	0	121

(1968-1969)
FINANCIAL STATEMENT

Medical	$130,658.15
Chiropractic	4,670.00
Podiatry	2,160.00
Physical therapy	3,381.00
TOTAL REVENUE FOR REGISTRATION YEAR	$140,869.15
1. Personal services	47,112.30
2. Telephone and postage	3,603.88
3. Printing, rent, contractual and FLEX Examination	35,220.66
4. Office supplies	258.42
5. Office equipment	441.71
8. In-state travel	7,514.08
9. Out-of-state travel	247.60
TOTAL DISBURSEMENTS	$ 94,398.65
REVERTED TO GENERAL FUND	$ 46,470.50

Reports of Standing Committees and Commissions

Executive Committee

HOUSE ACTION: Accepted for information.

The Executive Committee has met regularly throughout the year, usually with a full attendance of all members. I think it is unnecessary to go into great detail as to the activities of our committee inasmuch as the minutes have been published regularly in *The Journal* and widely distributed. Also copies of all minutes are being made available to the Reference Committee for their review.

However, in addition to the normal routine housekeeping responsibilities of the committee, I would like to call your attention to just a few of the matters handled by the Executive Committee during the past year.

(1) Recommended to the Board of Trustees the installation of a 24 hour recording service.

(2) Recommended to the Board of Trustees that cooking equipment be installed in the basement of the building.

(3) Recommended to the Board that the officers of the association take a course in public speaking.

(4) Approved certificates for presentation to past AMA delegates and members of the association who have served on the Council and other officers.

(5) Offered secretarial services to specialty groups of the state.

(6) Referred two delinquent student loan accounts to legal counsel for collection.

(7) Referred to Commission on Emergency Medical Services, for their review and report, "Changes in Standing Orders for Emergency Rooms of Hospitals."

(8) Authorized proposed resolutions for presentation at the American Medical Association Clinical Session.

(9) Referred to the Board a request that the association establish a Sports and Medicine Committee.

(10) Met with Indiana delegation to the American Medical Association meetings.

(11) Authorized the president to establish an Advisory Committee to the President.

(12) Recommended the establishment of a policy of having candidates for offices in the American Medical Association to

appear before the Indiana delegates and the Executive Committee prior to election for their various offices.

(13) Recommended to the Board that a survey be made concerning the backlog of payments to M.D.'s by welfare and township trustees.

(14) Referred to the Board problems of county society attempts to obtain usual and customary fees in welfare contracts.

(15) Voted to support the Youth Power Conference and the Health Careers program.

(16) Referred to the Board a resolution supporting the establishment of a medical examiner system by the state legislature.

(17) Referred to the Board for their consideration a recommendation that new members pay a $50 entrance fee for supporting the upkeep of the building.

(18) Reviewed all legislative matters referred to the committee by the Commission on Legislation.

(19) Authorized the re-establishment of the County Society Officers Conference.

(20) Reviewed the action of the Oklahoma Medical Association requiring their members to complete 30 hours of postgraduate work annually as a basis for continuing membership.

(21) Referred to the Board the suggestion of changing title of executive secretary to a title in keeping with other organizations.

(22) Referred to the Board the question of the past president being included as a part of the Indiana delegation to the American Medical Association.

(23) Held two joint meetings with the Executive Committee of the Indiana Hospital Association for discussion of mutual problems.

(24) Recommended to the Board of Trustees that they study the financial needs of the association and consider making a recommendation of a $5.00 annual dues increase instead of waiting and then having to make a sizeable dues increase at one time.

(25) Authorized purchase of kits on "Defense Against Quackery" for distribution at Regional School Health Conferences.

(26) Approved renewal of membership in the United States Chamber of Commerce.

(27) Welcomed American Medical Association Council on Voluntary Health Agencies to hold a 12 state regional meeting in Indianapolis October 11 and 12.

(28) Approved the suggestion of the president to establish a meeting of hospital chiefs of staff, hospital administrators and trustees and authorized the president to work out the program.

(29) Recommended to the Board of Trustees that they study the idea of recommending an amendment to the Constitution and Bylaws that all elections held at the county and district level be done by mail ballot.

(30) Accepted an offer of the A.H. Robins Company to supply an award to a physician for his community service.

(31) Approved a substandard insurance program as recommended by the Commission on Medical Economics and Insurance for offering to members who could not qualify for the present program.

(32) Approved the establishment of a joint advisory committee to be composed of hospitals, insurance companies and physicians for the purpose of resolving insurance problems.

(33) Ordered distribution of American Medical Association definition of "usual", "customary", and "reasonable" to all Indiana insurance companies.

(34) Referred to the Board of Trustees a letter from the State Health Commissioner concerning the change in the use of silver nitrate in the eyes of the newborn.

(35) Approved a request of the Board of Health for plans for distribution of RH_0 (D) Immune Globulin-Human.

(36) Requested republication in *The Journal* of the Medical-Legal Code.

(37) Approved the suggestion of the president that he contact non-members urging them to join their county society, the state association, and the American Medical Association.

(38) Approved the executive secretary serving on an advisory committee for the program on Emergency Medical Services.

(39) Referred to the Board the question of air conditioning of the building.

You will see from this abbreviated rundown, which does not begin to cover the matters which came before your Executive Committee, it is evident that your committee has had a busy year.

Medical Defense Activities

1. *Malpractice Cases.* A year ago, at the time of this report, August 1, 1968, the following four cases were pending before the committee:

Case 307—Suit filed March 22, 1962. Pending. (Expense to date $1,042.73).

Case 309—Suit filed December 10, 1964. Pending.

Case 312—Suit filed December 7, 1965. Pending.

Case 313—Suit filed September 5, 1967.

Since August 1, 1968, and up to August 1, 1969, no new cases have been filed.

2. *Medical Defense Fund Statement from August 1, 1968 to August 1, 1969:*

Bank Balance,		
August 1, 1968		$3,153.79
Investments,		
Treasury Bonds		25,000.00
		28,153.79
Receipts:		
Dues	$4,998.75	
Interest	960.53	
		5,959.28
Total cash and receipts +investments		$34,113.07
Disbursements:		
Attorney Fees	$3,848.61	
		3,848.61
Balance on hand August 1, 1969		$30,264.46

The Journal

The financing problems of *The Journal* remains one of our biggest headaches. What we have gained in reduction of production costs has been offset in the drop in revenue from advertising. The advertising continues to fluctuate and at the rate we are going for '69, the income from advertising may be one of the lowest since 1966. Despite the financial situation, it does not seem prudent to lower the standards of *The Journal*, which is recognized as one of the best state journals published.

Listed below is a comparative report of *The Journal* operations over the past several years and the first six months of 1969.

Below are figures revealing price per page increases of *The Journal* (excluding inserts)

1965	$2.54	
1966	$2.96	
1967	$3.45	
1968	$3.47	
1969	$3.19	(First six months)

The table below shows the total printing costs of *The Journal*:

Year	Total Printing Cost	No. of Pages (Inserts excluded)
1965	$35,957.50	1416
1966	$41,795.32	1410
1967	$49,958.15	1450
1968	$50,709.62	1463
1969 (6 months)	$21,042.28	660

The following table shows the number of journal pages for the past six years (includes inserts).

Year	Reading	% Reading	Adv. Pages	% Adv. Pages	Total Pages	Av. Pages per Issue
1963	1139	70	487	30	1626	135
1964	1051	71	423	29	1474	123
1965	998	68	464	32	1462	122
1966	789	50	781	50	1570	131
1967	1041	58	751	42	1792	149
1968	1068	61	696	39	1764	147

Advertising volume for the first six months of 1969 is down. We are hopeful that in the month of September, which is forecast as a good advertising month, that advertising might increase sufficiently to offset the loss of most of the income for the first six months and bring us up to a figure more nearly equal to those of previous years.

A comparison of advertising revenues for the first six months of the last four years, with a like figure for 1969 is as follows:

	1965	1966	1967
State Medical Journal Adv. Bureau	$13,927.88	18,069.54	23,468.96
		1968	1969
		24,153.24	17,086.59
	1965	1966	1967
Sold Direct by Journal	$2,812.74	2,687.76	3,056.68
		1968	1969
		7,200.10	2,557.80
	1965	1966	1967
Total	$16,740.62	$20,757.30	$26,525.64
		1968	1969
		$31,353.34	$19,644.39

RALPH V. EVERLY, M.D.,
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LOWELL H. STEEN, M.D.
LESTER H. HOYT, M.D.
MALCOLM O. SCAMAHORN, M.D.

Grievance Committee

HOUSE ACTION: Accepted for information.

The Grievance Committee held meetings on September 29, 1968 and April 20, 1969.

As of July 1, 1969, 18 cases were considered during the year. Six new cases were filed during the year. Most of these and old cases pending have been closed. There are six cases pending at this time.

As usual, a number of other complaints were received which were not acceptable cases for the Grievance Committee to consider. These are the type of letters which include grievances and complaints, but the person does not care to be identified or doesn't wish to follow it up after we write them. The Grievance Committee as a first step in handling legitimate complaints encourages the physicians charged to attempt a friendly discussion with the complainant. If this approach is unavailing, we persist in our efforts at local judication by asking the county medical society to attempt resolution of the problem. It is only when this effort fails or when local judication is declined that your state Grievance Committee proceeds or acts as directed by the House of Delegates. It should be noted that we are trying to handle as many of these cases locally as possible. Thorough investigation is being made into all cases which come before us.

The House of Delegates in 1967 approved the request of the Grievance Committee that legal counsel bring up to date the *Purposes, Rules and Procedure of the Board of Appeals on Patient-Physician Relations.* Dr. Philip Reed, chairman of the committee in 1967, found it necessary to resign because of moving to Florida and there has been a change in legal counsel and this matter has not been completed. Therefore, we would ask the approval to employ current legal counsel to do this work for the Grievance Committee.

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JOHN M. PARIS, M.D.
WILSON L. DALTON, M.D.
WILLIAM R. NOE, M.D.
HUGH K. THATCHER, M.D.

Student Loan Committee

HOUSE ACTION: Accepted for information.

The Student Loan Committee held four meetings during the past year. The committee interviewed 15 students, and loans were granted to all applicants for a total of $15,000.00.

Under the Guaranteed Loan Plan with the Indiana National Bank, which was instituted December 1, 1963, the association has on deposit with the bank $20,810.00 to guarantee loans totaling $260,000.00. As of July 31, 1969, 96 loans, totaling $83,800.00, have been granted under this plan. Thirty-eight loans have been converted to installment loans in the amount of $34,960.10. To date there have been two defaults — one in the amount of $606.54 and the other in the amount of $1,913.00. The Indiana National Bank has been reimbursed for these two loans from the Student Loan Fund. Legal counsel of the association has been instructed to investigate the possibility of collecting these sums from the two physicians.

A report on the Loan Fund which was under association management from October, 1955, to December 31, 1963, follows:

Total loaned to 117 students	$58,458.36
Total repaid by loanees as of July 31, 1969	55,468.32
Total amount outstanding, July 31, 1969	$ 2,990.04
Of the 117 who received loans, 109 have repaid in full	
*8 are making payments	(2,990.04)
*Total due on above 8 loans still outstanding	2,990.04

The balance of $63.66 on one loan was written off because of death.

All delinquent accounts have been given to legal counsel for collection.

It is believed that the Student Loan Fund is providing an essential service to students in need of financial help and in view of the fact that there are only two defaults in our association with the Indiana National Bank this type of loan procedure should be continued.

LESTER D. BIBLER, M.D.,
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JAMES O. RITCHEY, M.D.,
Vice-Chairman
PATRICK J. V. CORCORAN, M.D.
LESTER H. HOYT, M.D.
GLENN W. IRWIN, JR., M.D.
JOE DUKES, M.D.

Medical-Legal Review Committee

HOUSE ACTION: Accepted for information.

I am pleased to report that the chairman of the Medical-Legal Review Committee met with the members of the Indiana State Bar Association, Medical-Legal Review Committee, on April 17, 1969.

None of the grievances presented at that meeting were against members of the medical profession. I believe the most significant business which was transacted at that meeting was that Mr. Henry E. Bradshaw who is chairman of the Indiana State Bar Association, Medical-

Legal Review Committee, is contacting the California Bar Association to determine their method of operation of their Medical-Legal Review Committee which screens possible medical-legal action to determine if the case merits filing. After the information is returned to Mr. Bradshaw he will call another meeting of the combined committee so that we can attempt to work out a similar type of arrangement between the Indiana State Medical Association and the Indiana State Bar Association.

We have put together what I believe to be an interesting medical-legal symposium to be presented at the meeting of the state society, and your presence at the symposium should be beneficial to you and would also be appreciated by the members of the panel.

R. L. NEWNUM, M.D., *Chairman*
WALTER ABLE, M.D.
JOSEPH G. S. WEBER, M.D.

Supplemental Report Future Planning Committee

HOUSE ACTION: Approved and referred to the Board of Trustees.

Continuing changes to improve the delivery of health care are as inevitable as they are desirable. American medicine owes its current excellence to the ability of its physicians to anticipate, comprehend and adapt new technologies to the care of patients. Some electronic devices, such as x-ray, and the electrocardiogram, are now universally accepted and utilized, even though they have brought with them significant modifications in health care.

Already a new more powerful electronic device, the computer, is making and will make a marked impact on the future health care of Americans. This versatile machine will prove to be an invaluable assistant to the busy physician in the daily care of his patients. Pioneering pilot adaptations are already well underway. Others will follow. Medicine need not fear this new technology, if, and only if, physicians actively participate in the adaptation of this technology to the care of their patients. With physician leadership, the computer programs will work for *us*. With our opposition, there will be attempts to replace us with computer programs. Because the latter alternative carries such a high risk to our patients' health, we can not afford to take an oppositional or even passive stance towards computerized health care programs. Therefore, physicians should be encouraged to experiment in the development of new methods for delivery of health care.

G. O. LARSON, M.D., *Chairman*
A. W. RATCLIFFE, M.D., *Vice-Chairman*
ED TYLER, M.D., *Secretary*
MAURICE E. GLOCK, M.D.
JAMES FITZPATRICK, M.D.
PAUL A. F. WALTER, M.D.
CHARLES F. GILLESPIE, M.D.
LESLIE BAKER, M.D.
PATRICK J. V. CORCORAN, M.D. (*Ex-Officio*)
LOWELL H. STEEN, M.D. (*Ex-Officio*)
DONALD R. TAYLOR, M.D. (*Ex-Officio*)
RALPH V. EVERLY, M.D. (*Ex-Officio*)
FRANK B. RAMSEY, M.D. (*Ex-Officio*)

Committee on Sports and Medicine

HOUSE ACTION: Accepted and recommended more publicity be given this activity.

The newly organized Committee on Sports and Medicine met on January 26 and outlined for themselves a program of activity for the year.

A guest for this meeting was Dr. Fred V. Hein, Director of the American Medical Association's Department of Health Education. Dr. Hein advised the committee of the materials and films which are available from the AMA on the subject of sports and medicine.

The committee also discussed at length physician coverage of sports events and activities and methods of safeguarding athletes at both practice and competitive sessions.

It was agreed that regularly scheduled annual or biannual courses should be offered physicians, coaches and trainers throughout the state.

Culmination of these discussions was a special one-day postgraduate course on "Sports Medicine for Physicians" held in conjunction with the Indiana University School of Medicine. The course was scheduled for September 3, 1969.

Subjects included weight reduction and preschool conditioning for high school athletics, facts and fallacies in nutrition for the athlete, head and neck injuries, heat exhaustion and taping procedures.

Other subjects scheduled were anatomy of the knee, knee injuries and the role of the physician in pre-high school and high school athletics.

The course was acceptable for eight hours of credit by the American Academy of General Practice.

Participating in the program were members of the ISMA committee, Indiana University School of Medicine faculty, the Indianapolis Veterans Hospital, coaches, trainers, high school athletic department heads and the Commissioner of the Indiana High School Athletic Association.

A meeting of the sports physicians, athletic directors, coaches, trainers and officials has been scheduled for November 13, 1969, in Indianapolis. This will be a meeting sponsored jointly by the Sports and Medicine Committee of the Indiana State Medical Association and the Indiana High School Athletic Association. Participants in the program will be members of the Committee on Sports and Medicine; Mr. Phil Eskew, Commissioner of the High School Athletic Association; high school coaches, athletic directors and officials from the central area of Indiana.

Also prominent in the committee's discussions during the year were comments relative to medical supervision of certain conditioning practices in wrestling and to the advisability of establishing statewide conditioning standards and the concept that a single physician be empowered with the final responsibility for determining the capacity of an athlete for competition with a given team.

THOMAS A. BRADY, M.D., *Chairman*
JAMES B. WRAY, M.D., *Secretary*
JAMES H. BELT, M.D.
BRAD J. BOMBA, M.D.
LELAND G. BROWN, M.D.
ARTHUR L. MOSER, M.D.
GILBERT M. WILHELMUS, M.D.

Committee on Medicine and Religion

HOUSE ACTION: Accepted for information.

"Hellfire and condemnation" are not the preoccupations of this Committee on Medicine and Religion. Although there are probably some patients who think we doctors need a little condemnation given with a little hellfire for seasoning.

What this committee has been concerned with is the launching of a new program on medicine and religion to help patients by helping their doctors and their ministers work with the patient. Have you, as a doctor, had, say, an inoperable cancer in a young patient and you would like to have help breaking the news to the patient? Maybe you are fortunately on friendly terms with the patient's minister. You have an opportunity to talk it over with the minister and he, being versed in *crisis counseling*, said, "Sure! I'll see him with you!"

You were able to do your job, taking care of the disease, and you were able to delegate the part not so well trained for—the humanitarian touch.

This is a new committee of the Indiana State Medical Association. We want to get good live committees in each county. We want your county to see the two new movies available through Reverend Doctor Paul McCleave, Director, AMA Department of Medicine and Religion. These films emphasize the concept of the "physician, the clergy and the whole man."

The following topics are areas which this committee might limit our activities to save for the next year or so:

1. "Sick Sex"
2. Drugs and Other "Hang-Ups"
3. Guilt, Grace and Good Health

There are many other committees within ISMA and within communities over the state concerned with these problems. We could delineate the areas to be handled by this committee and thereby make action in these directions more effective. Would you kindly send any questions or any information that you might have to this committee regarding medicine and religion as it might affect the people of the state, particularly the people that you take care of as patients? We doctors of Indiana should be able to demonstrate that we have a humanitarian interest in our patients at heart.

BURTON E. KINTNER, M.D.,
Chairman
HELEN M. CALVIN, M.D.
JOHN C. SLAUGHTER, M.D.
JOHN E. READ, M.D.
EDWIN B. BAILEY, M.D.
RICHARD M. NAY, M.D.
LEROY D. KINZER, M.D.

Commission on Constitution and Bylaws

HOUSE ACTION: The following amendments to the Constitution were introduced and approved but will lay over for a period of one year before final action is taken.

The Commission on Constitution and Bylaws had several matters referred to it for consideration and makes the following recommendations for changes in the Constitution:

Article IV, Section 1. BE IT RESOLVED that Article IV, Section 1 of the Constitution be amended to read as follows: "The Association shall consist of Active Members, Associate Members, Senior Members, Honorary Members and Disabled Members."

Article IV, Section 3. BE IT RESOLVED that Article IV of the Constitution be amended by adding a Section 3, which shall read as follows: "Sec. 3. Interns and Residents. Interns and Residents who hold membership in the Indiana State Medical Association shall have all the rights and privileges of this Association except the right to hold office and to vote."

BE IT FURTHER RESOLVED that Article IV be further amended by renumbering the present Section 4 to Section 5; by renumbering the present Section 5 to Section 6; renumbering the present Section 6 to Section 7 and renumber present Section 7 to Section 8.

Article IV, Section 7. BE IT FURTHER RESOLVED, that Article IV be amended by adding a new Section 7 to read as follows: "Sec. 7. Disabled Members—Disabled Members shall consist of physicians of the state of Indiana who are certified by their county medical society to be permanently disabled and no longer able to practice medicine and who continue to reside within the state of Indiana, and shall have the same rights and privileges as a Senior Member."

Article IV, Section 8. BE IT FURTHER RESOLVED, that Article IV, present Section 6 be renumbered Section 8 and amended to read as follows: "Sec. 8. Rights and Privileges of Members—Active Members, Senior Members and Disabled Members shall have the same rights and privileges except as follows:" (the balance of this Section to remain the same).

Article XI, Section a. BE IT RESOLVED, that Article XI, Sec. a of the Constitution be amended to read as follows: "a. Membership dues to be collected may be collected by the Indiana State Medical Association or by the component county societies in connection with the dues for such component societies. The amount of dues of each component society shall be fixed by the society itself; and the amount of dues for this Association shall be fixed from time to time by the House of Delegates."

Bylaws

HOUSE ACTION: The following amendments to the Bylaws were adopted.

Chapter I, Sec. 2. "The term "member" as used in these Bylaws, unless otherwise indicated, shall mean both active and Senior Members of component county medical societies who hold either the Degree of Doctor of Medicine, Bachelor of Medicine, or who hold an unrestricted license to practice medicine and surgery."

Chapter VIII, Section 1. BE IT FURTHER RESOLVED that Chapter VIII, Section 1 be amended to read as follows: "Following the line "The Commission on the Aged and Aging" add the following: "The Commission on Emergency Medical Services"; "The Committee on Sports and Medicine"; and "The Committee on Medicine and Religion". (The balance of the Section to remain as is)."

Chapter VIII, Sec. 2. BE IT FURTHER RESOLVED that Chapter VIII, Sec. 2 of the Bylaws be amended to read as follows: "Sec. 2. Committees. Except when otherwise stated in the Bylaws, a committee shall consist of not less than five nor more than nine members and shall be appointed annually by the president. The president shall also appoint the chairman and the vice-chairman of each committee."

Chapter VIII, Sec. 3. BE IT FURTHER RESOLVED that Chapter VIII, Sec. 3 of the Bylaws be amended by adding the following at the end of the present section: "The President shall also appoint the chairman and the vice-chairman of each commission."

Chapter VIII, Sec. 6. BE IT FURTHER RESOLVED that Chapter VIII, Sec. 6 be amended by deleting the second sentence in the section, beginning with the word "Then" and ending with the word "Bylaws" which would then make the section read, "Sec. 6—Within sixty days after the meeting of the state convention, the president will call all commissions and committees into a joint meeting in which he will give a statement of the duties and responsibilities of all committees and commissions, call special attention to any immediate problems confronting the Association, and assign such problems or parts thereof to appropriate committees and commissions. In these meetings the commissions may provide for such subcommittees within the separate commissions as they may deem advisable. Each committee or commission shall have the right to call upon other committees, commissions or members of the profession for counsel and advice with respect to its work."

Chapter XXVI. BE IT FURTHER RESOLVED that a new Chapter be added to be numbered Chapter XXVI, to read as follows: "Chapter XXVI.—The Commission on Emergency Medical Services. Section 1. The Commission on Emergency Medical Services constituted as provided herein shall have as its purpose the survey, planning and evaluation of emergency medical services to insure that the medical profession will guide and influence the services for the greatest benefit and protection of the public."

Chapter XXVII. BE IT FURTHER RESOLVED that a new Chapter be added to be numbered Chapter XXVII, to read "Chapter XXVII—The Committee on Sports and Medicine."

Chapter XXVIII. BE IT FURTHER RESOLVED that a new Chapter be added to be numbered Chapter XXVIII, to read: "Chapter XXVIII. The Committee on Medicine and Religion."

The Constitution and Bylaws Commission further requested that chapters be renumbered as follows: BE IT FURTHER RESOLVED that present Chapter XXVI be re-numbered XXIX; Chapter XXVII be re-numbered Chapter XXX; Chapter XXVIII be re-numbered XXXI; Chapter XXIX be re-numbered Chapter XXXII; Chapter XXX be re-numbered XXXIII; Chapter XXXI be re-numbered XXXIV; Chapter XXXII be re-numbered XXXV; and Chapter XXXIII to XXXVI.

Chapter XXX, Sec. 4. BE IT FURTHER RESOLVED that new Chapter XXX, Sec. 4, be amended to read as follows: "Sec. 4. —Each county society shall be judge of the qualifications of its own members, but, as such societies are the only portals to this association and to the American Medical Assoeiation, every reputable and legally registered physician who holds a Degree of Doctor of Medieine, a degree of Bachelor of Medicine, or who holds a valid, unrestricted license to practice medicine and surgery, and who does not practice or claim to practice, nor lend his support to, any exclusive system of medicine, shall be eligible for membership. Provided, however" . . . . . balınce of this section to remain the same).

New Chapter XXX, Sec. 12. BE IT FURTHER RESOLVED that new Chapter XXX, Sec. 12, the second paragraph, be amended to read as follows: "Unless collected by the Indiana State Medical Association, the secretary of each component society shall forward the dues for his society to the executive secretary of this association and shall furnish the state association headquarters with a roster of officers, members and a listing of non-affiliated physicians of the county, on or before January 1 of each year, and he shall promptly report thereafter the names of any new members elected to membership in his society, and promptly forward to the executive secretary of this association the dues for such members."

New Chapter XXXI, Sec. 5. BE IT FURTHER RESOLVED that new Chapter XXXI, Sec. 5, be amended to read as follows: "Sec. 5. The dues of the district society, in an amount fixed by the district society to meet the district society needs, shall be collected by the secretaries of the component county societies, or by the Indiana State Medical Association, and delivered to the treasurer of the district society. The secretary of eaeh district society shall report to the office of the Indiana State Medical Association the names and addresses of the members of his district society, together with a copy of the minutes of each meeting of the district society."

HOUSE ACTION: The proposed amendment to Chapter XXXI and Resolution 69-7 related to the same subject and were considered together. Neither was adopted.

Codification of Constitution and Bylaws

HOUSE ACTION: The House approved the request of the Commission on Constitution and Bylaws to employ the association attorney to recodify the Constitution and Bylaws and to later meet with the commission for their consideration of this recodification.

Legislation

HOUSE ACTION: Adopted.

Following is a report on what happened in the last legislature and those bills of importance to you.

The first is Senate Bill 33 which compels testimony of witnesses regardless of the constitutional privilege and provides immunity from prosecution for crimes exposed by the testimony. This bill became law.

The next one is the glue sniffing law. This was labeled as a misdemeanor and levies a penalty. This bill was signed into law, and as all of you know, some of the kids today go around sniffing glue and here's a real thing that you can tell them . . . we've got a law against it.

The next important one provides for a Commission for the Handicapped to develop a plan of services for multiple handicapped people, including the possible construction of a state facility. This bill was passed but it was vetoed by the Governor. This is one of the bills that ISMA supported as a package group that was put in by the State Board of Health in trying to help the handicapped throughout our state.

Senate Bill 52 authorized the State Board of Health to conduct a demonstration project involving the handicapped in order to develop state programs for the care and treatment of multiple handicapped persons. This bill didn't get to the Governor. It died in the committee.

The next was a bill that required that birth certificates of children born out of wedlock include the birthplace of the mother and father. This bill became law.

Senate Bill 57 amends the Air Pollution Control Act and establishes means to certify automobile air pollution control equipment, permit declaration of air pollution as an emergency and provide a fine of $500 per day for violations. As you know, air pollution has been one of the major concerns of the AMA, the national congress, as well as our own state organization and our state legislature.

Senate Bill 81 goes back to Dr. Rifner's time. This year all counties, cities and towns must by January 1, 1971, close all open dumps.

Senate Bill 89 is a universal bill that has been encouraged by the AMA to be passed in all states. It's the Uniform Anatomical Gift Act which authorizes gifts of all or part of a human body after death for medical and scientific purposes. This bill has been signed into law.

Senate Bill 118 eliminates the requirement that the cost of maintenance of mentally ill patients in family boarding homes shall not exceed the cost in a state hospital. This bill also became law. This takes out the possibility of a family profiting on the illness of some one member of their own family.

Senate Bill 201 permits the State Board of Health to subsidize local health departments. This is in the nature of sanitary engineers and to provide suitable staffs within the county health organization as is required. This bill we supported as one of the pluses in our efforts.

Senate Bill 215 makes it unlawful to drive under the influence of any dangerous depressant or stimulant drug in addition to habit-forming drugs as provided under the existing law. This is another one that we supported and became law.

Senate Bill 216 prohibits the issuance of a driver's license to any person determined to be a user of any dangerous, depressant or stimulant drug. This bill also became a law and was actively supported by your commission.

Senate Bill 225 requires the suspension or revocation of a driver's license and registration of any person convicted of possession, use or sale of narcotics or habit-forming drugs. This also became law and we supported it.

Senate Bill 348 revises the 1967 Meat Inspection Law to conform to the federal law and extends the mandatory date for inspection to November 15, 1970. This is one of our bills in conjunction with the State Board of Health that we supported and is another plus for us.

Concerning House Bills, the first was House Bill 1072 which provides for the implementation of Title XIX of the Social Security Act in the state of Indiana by January 1, 1970. This bill became law and as you know, your state organization

did not take any stand for or against it but when we were asked, we did say that we felt that the approach to the problem was to take the minimum approach in view of the experience in many other states throughout the country. To further amplify this, Title XIX encompasses all the present health agencies such as Aid to Dependent Children, the Blind, Old Age and the Disabled. As you know, in our law, we require citizenship and also residency requirements. This would take care of that particular position to make us comply with the federal law. The second one is for children under 21 whose families do not have resources to give health assistance to those individuals under 21. This particular new concept of Title XIX in Indiana will enable us to do something about that. The anticipated cost is $270,000 for the biennium. This is part of the $14,000,000,000 total health care program for the biennium in the state.

House Bill 1151 requires doctors, hospitals, health and welfare departments and superintendents of state institutions to report handicapped persons to the State Board of Health who shall compile and analyze such reports. So, you have one more report to make to the State Board of Health. This became a law.

House Bill 1165 is the Implied Consent Law in which a person agrees when arrested for driving under the influence of intoxicants to be subjected to a breath test and authorizes the commissioner of the Bureau of Motor Vehicles to suspend his license for a period of not to exceed one year for failure or refusal to submit to a breath analysis. This bill was supported by your organization as directed by the House of Delegates and it became law.

House Bill 1240 provides that the insurance policies issued after the effective date of this act, which is April 1, 1969, shall provide for the payment of services performed by chiropractors, osteopaths and optometrists. This bill became law. As late as the day before the Governor signed the bill, he said he would not sign it, so this you can count as a loss in our program.

House Bill 1261 permits a person under 21 who has, suspects, or has been exposed to any venereal disease, authority to give his or her consent for care and treatment of the disease. This bill became law. They can now go to a doctor and assume responsibility for their own care.

House Bill 1338, an association bill, declared that blood and blood products, as well as tissues, are a medical service rather than a sale. This died in the Judiciary Aid Committee in the Senate. They had the feeling that we were trying to legislate a lack of responsibility and we could not get the true importance of this bill across to that particular committee so we lost. That's another minus.

House Bill 1344, another one of our bills, created a division of medical care and treatment in the Department of Correction and placed an M.D. in charge. This died in the House committee. Again, we were unable to get our point across and this is another negative against us.

House Bill 1375, a bill to provide for certification of qualified psychologists, became a law effective July 1, 1969. We supported this bill and they came to our organization long before the bill was written. We all got together and made it, what we felt, was a good bill.

House Bill 1468 amended the Medical Practice Act by deleting the limitation of a charge of $25 to take the examination and replacing it with a fee not to exceed $100. This bill passed and became law. This enabled the state board to accept the FLEX examination rather than the written examination as has been customary in the past. This is going to be a good bill that will eliminate a lot of problems, not only at the university level, but certainly in some of our Departments of Correction, for example, where we can now get people to come into the state and not have to take the examination. This is one of the very good pluses.

House Bill 1583 authorizes the podiatrist to administer and prescribe certain drugs. It does, however, prohibit the use of anti-inflammatory, systemic drugs, such as cortisone, etc.. This passed both houses and became law. With the direction of the House of Delegates, we did oppose this bill. The only thing it allows them to do is to locally treat the feet to try to prevent infection by capital application but they cannot use the steroid.

A bill for the licensing of physical therapy assistants died in the Senate committee. We did oppose it on the basis that they had so many people in the physical therapy schools now they didn't have enough professors.

House Bill 1756 created an Indiana Medical Education Authority of eleven individuals and authorized it to adopt a program to expand medical training resources, increase the number of medical graduates, to acquire a site and hire an architect for the construction of a school. This finally passed both houses but it was vetoed by the Governor.

House Bill 1775 authorizes the state Mental Health Department to establish a network of local community treatment centers for the treatment of drug abusers and this bill was also signed into law.

House Bill 1870 makes it unlawful for a person not admitted into the practice of medicine to represent himself as a physician. This bill passed the House but died in the Senate Committee on Courts and Criminal Code. We were in support of this.

House Bill 2000 prohibits children from attending school more than 30 days beyond enrollment without furnishing written proof of immunization and directs school authorities to file such proof with the State Board of Health within 60 days of enrollment. This bill was signed into law. As you know, these kids who have already been in school and come into your office and get a vaccination have created a lot of problems, so the State Board of Health has finally got this worked out so that this situation will no longer exist. We supported that bill.

Another bill authorizes the Board of Health to prescribe a form to use as written proof of TB tests for school children and directs that no child shall attend school for more than 30 days without written proof of such a test. This bill was also signed into law and we supported that.

There were many bills to create new medical schools and take over all the Marion County properties of Purdue and Indiana University and convert them into the University of Indianapolis. None of these bills were successful in becoming law, so as you can see, we had some 70 bills that were directly important to the practicing physician in this state and you see what the state organization is doing for you in the practice of medicine.

On the Washington scene it's important that you have some concept about what's going on nationally and as you know, the AMA, following the last election, has a little better report on the bills and in the White House than it did during the previous administration, and for this reason, you can anticipate that the AMA will have a forward, ongoing program. We will try not to be reactionary or put in a position of having to be reactionary, but we are hopeful that we can produce some legislation that will be helpful to the practicing physician. If it becomes necessary to become reactionary on any legislation, we certainly will do that, but we want to change our approach. Now, to review a few of the federal laws that are under consideration and some that will be of importance to you, HR 1, the first bill put in the House, has to do with the Uniform Service Academy of Health Sciences which establishes a Uniform Service Academy of Health in the District of Columbia area

and provides for a 15 man Board of Regents to govern the academy. The AMA position on this has always been one of opposition. AMA feels that the same amount of money given to already established medical schools would produce far more doctors than the establishment of a single medical school for armed forces personnel.

The next one was the Health Insurance Benefit Act of 1969 which is under discussion. This bill would amend the Insurance Revenue Code to provide a new system of income tax credits for the taxpayers. This, of course, is AMA policy. Congressman Fulton has already drafted a bill and AMA has been in conference with him in attempting to get the bill drafted so that it will embody the attitudes and ideas of the AMA of giving credits for the purchase of health insurance.

Now, HR 8 is the unofficial Organ Transplantation and Technological Development Act of 1968 which authorizes the development of separate centers for separate organs. AMA opposed this on the basis of the establishment of a kidney institute, a lung institute, a liver institute —it was felt that the benefits to the kidney treatment patients, regardless of age, would be an unwarranted expansion of the Medicare program.

The next one was a reasonable allowance for physicians' services under part B of Medicare. This bill amends the Medicare program to pay for physicians' services on the basis of "reasonable allowance" rather than the "reasonable charge" basis under the present law. The secretary of HEW was determined the allowance was different in geographical areas. This bill, as you can see, disregards the physician's customary charge as a proper basis of payment and would make the basis of payment the average payment made by a nonprofit, medical, prepayment organization such as Blue Cross or Blue Shield. AMA opposes that bill totally.

Then, there were many bills on drugs. In general, AMA supports the drugs in government-sponsored programs when furnished in relation to financial needs of the patient and providing there be no restriction on the physician's free choice of drugs other than in his own professional judgment. We think that you would all agree that as long as that general policy is followed that that would be within your own ideas.

Now to mention to you a few of the bills that are in the process of being sent to your Board of Trustees and then to the House of Delegates for possible implementation in an attempt to help again the private practitioner. Here again are some of the things that the AMA is doing for you, the private practitioner in medicine, regardless of where you practice.

This first one would be a bill to amend the anti-trust laws to provide that the refusal of non-profit blood banks in the hospitals and physicians that obtain blood and blood plasma from other blood banks shall not be deemed to be acts in restraint of trade. You see, we lost this bill at the local level, but there are many implications that are involved in this in which you, the physician, could actually be sued for improper administration of blood that might have hepatitis, for example.

Next are bills to create a national advisory commission to study devices; a bill to eliminate the recertification requirements for general inpatient hospital services under title XVIII and then remove limitations of psychiatric care under titles XVIII and XIX; a bill to permit direct billing of all title XIX recipients; a bill to enable the beneficiaries under title XIX in Puerto Rico and the Virgin Islands to have a free choice of providers and services, (they haven't that now); a bill to provide the option to receive hospital care and facilities other than in VA hospitals; a bill to amend the Military Selective Service Act of 1967 as it pertains to selective service call to physicians and to provide for allocation of health personnel among the armed forces, governments and civilians.

Then the next one would be the Occupational Safety Health Act of 1969 which has to do with hazardous agents. We here in Indiana have asked some legislation in that area but we have recommended opposition to the creation and enforcement of mandatory national standards for occupational safety and health, and we have urged instead that the setting of the standards should remain within the states and that the federal government can best serve the purpose of this bill by assisting them in upgrading and enforcing their own occupational safety and health program.

The next one, is a bill that you are all familiar with. It's the new modification of the Hill-Burton proposal. The Hill-Burton, as you know, was originally a hospital construction program but today much is being said of the needs of modernization instead of construction and perhaps there has been a change of attitude that the emphasis now under Hill-Burton has impetus of modernization. The states have been spending most of their money for rehabilitation, for modernization, etc. of existing facilities primarily in urban areas and there has been less emphasis on rural areas than there has been in the past. Secretary Finch has proposed that the grant system for hospital construction be ended and replaced by a loan guaranteed program. If you read some testimonies before the house committee, there was some comment by the press that the AMA was in opposition to Secretary Finch because he was supporting the loan and we had been supporting the grant position. Well, this is not true. We do not take any position on eliminating the grant factors or eliminating the loan factors. We thought perhaps in due time that probably the grant phase could be phased out but the AMA has supported a loan guaranteed program which is in many instances, preferred over the direct grants. In loan guaranteed programs, the government acts as a guarantor and subsidizes part of the interest payment that encourages the use of the program. The federal expenditure is really a minimal one so the AMA has given testimony to this fact and has supported it. We are in accord with Secretary Finch's idea. On HR 1159 which is the Assistant Secretary of Defense for Health Affairs, the AMA has not taken any action, other than to say that they would support this but again they feel that through Secretary Laird, they would have a good ear to discuss this problem. The AMA feels that he ought to have time to review his own organization and see whether this would really be a good idea from his point of view.

As you know, Senate Bill 16 is the Adult Protection Act of 1969, better known as Preventicare. This bill establishes a multiple screening program to provide a health evaluation of all individuals, 50 years or older, who wish to participate in the program. The bill provides for the establishment and operation of regional community health protection centers and for the training of personnel to operate such centers. A provision is also made for the conduct of research related to such centers and their operation. The AMA has taken a position of opposition at this time until such time as further studies are completed concerning the use, the cost and the reliability of multiphasic screening. In other words, the AMA does not think there's been enough real study in this area to come up with a real position.

DON E. WOOD, M.D.,
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Vice-Chairman

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FRED W. DIERDORF, M.D.
JOHN DAVIS, M.D.
JACK L. ALEXANDER, M.D.
MAX N. HOFFMAN, M.D.
DANIEL RAMKER, M.D.
LESTER RENBARGER, M.D.
OTIS R. BOWEN, M.D.
JACK W. HICKMAN, M.D.

Public Information

HOUSE ACTION: Adopted with the recommendation that the Board of Trustees consider the appointment of a professional staff in this area.

The Commission on Public Information met twice during the year to consider items of concern to the commission.

The following activities have comprised the activities of the commission for the year:

1. *Teacher Kit on Quackery*: The commission made plans to supply to school and community health workshops annually throughout the state in various regions, kits of these materials which are produced by the American Medical Association.

2. *Preceptor Program Film*: The commission encouraged the production of this film for educational purposes both for county medical societies and high school students and at the time of this report plans are being made to go into production on the film, in conjunction with the film department of the Indiana University School of Medicine in September.

3. *President's Tour*: The commission studied a plan utilized by the Illinois State Medical Society each year in which the president of the state medical association schedules appearances throughout the state to speak to such groups as Kiwanians, Rotary Clubs, Elks Clubs and other such groups on the socio-medical-political philosophies and aspects of organized medicine. Such appearances in a community would constitute a day long tour and would include radio and television appearances, as well as news conferences and interviews. The commission feels that such a plan would be an excellent public relations and public information program and encourages the adoption of such a program on an annual basis. Local plans for such a presidential visit could be coordinated through the county medical society.

4. *Film "Horizons Unlimited"*: A copy of this film was purchased by the association and loaned to Indiana Health Careers, Inc., for showing to students throughout the state at high school convocations which are organized each year by the health careers group to encourage young people to consider careers in medicine and allied health professions.

5. *Journalism Awards Program*: This program continues under the sponsorship of the Public Information Commission. There is, however, a need for more recognition of the value of this public relations program by county medical societies, through which all applications for awards are channeled. These awards are made annually at the convention of ISMA.

6. *Community Service Award*: The commission at the direction of the Executive Committee instituted a community service award for physicians this year. The commission established criteria for the award and advised county medical societies of the award and urged submission of applicants. The A. H. Robins Pharmaceutical Company provides the plaque for the awardee.

7. Generally, in the area of public information, the following additional activities were conducted:

--Arranged for and manned an exhibit on medicine as a career for a health careers conference and workshop at Indiana Central College.

—Aided in the planning for a health exhibit at the Marshall County Fair.

—Distributed health literature to Welcome Wagon hostesses throughout the state.

—Provided AMA Drug Abuse Kits to physicians and teachers upon request for utilization in school lectures and teaching.

—Provided publicity releases for various publications and newspapers throughout Indiana.

—Provided background and resource information to newspaper feature writers and columnists on such matters as venereal diseases, smoking, drug abuse, sex, and statistics, including physician population in Indiana, etc.

In conclusion, the commission would like to reemphasize its role as the commission through which other commissions should direct matters which would have public information import. With this in view the commission notes with a great deal of interest two specific programs which have great public information potential, specifically, the developing activity of the Commission on Emergency Medical Services and its cooperative emergency sign program with the State Highway Department and the three day health conference for high school students presently being planned by the Board of Trustees for April 9, 1970. Such programming is the essence of good public relations for ISMA.

WILLIAM B. CHALLMAN, M.D., *Chairman*
WILLIAM G. MOORE, M.D., *Vice-Chairman*
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RICHARD S. BLOOMER, M.D.
ROBERT D. SPINDLER, M.D.
ROBERT W. HARGER, M.D.
CHARLES R. ALVEY, M.D.
DON W. BOYER, M.D.
SEYMOUR W. SHAPIRO, M.D.
REEVE PEARE, M.D.
FRED DAHLING, M.D.
VICTOR JOHNSON, M.D.

Governmental Medical Services

HOUSE ACTION: Adopted.

The commission has considered many matters during the past year and many of them have been discussed.

We have:

1. Reviewed many of the unusual and outstanding CHAMPUS claims (old Medicare and dependent's care.) Two or three members of the commission have reviewed these claims.

2. We are still in strong support of physicians being placed on the State of Indiana Correction Board. (We feel that a physician is needed to help advise the medical facilities of our prison, penitentiary and other correctional institutions.)

3. There has been discussion about a published Rule Book on Extended Care in Medicare. This was to have been presented to physicians but it is not in appearance at this date.

4. The Indiana Regional Medical Program is now in operation. Reports have been made that grants of over one and one half million dollars for the year 1969 were allotted to projects in the area of stroke, coronary care, cancer, multiphasic health screening and community health center. (Recently the Coronary Care Unit of Marion County General Hospital has been linked by telephone to a nearby county hospital. In this manner a cardiologist interprets a patient's EKG often and as quickly as is needed in critical cases.)

The Indiana Regional Medical Program is coordinated by Robert B. Stonehill, M.D.

The commission urges physicians to make their local needs known to the Indiana Regional Medical Program.

JEROME E. HOLMAN, JR., M.D., *Chairman*
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DICK J. STEELE, M.D.
TOM S. SHIELDS, M.D.
ROBERT P. SCOTT, M.D.
J. F. HINCHMAN, M.D.
EDWARD J. DIEROLF, M.D.
DONALD K. WINTER, M.D.
MICHAEL J. MASTRANGELO, M.D.
D. D. SWIHART, M.D.
ANDREW C. OFFUTT, M.D., (advisory member)

Public Health

HOUSE ACTION: Adopted.

The Commission on Public Health met four times during the year.

At its initial meeting the commission visualized its role as an investigative one with the objective of keeping the association informed and exercising influences upon appropriate legislation, institutions, associations, other bodies, and the membership for the betterment of public health.

Considerable discussion during the year was given to the topics of driver examinations and medical examinations for the elderly, reporting by physicians of physical impediments relative to licensing, drug administration and/or abuse, and the use of alcohol combined with driving.

It was felt that since all of these areas are involved in licensing of drivers, that law enforcement representatives should be consulted.

As a result the commission invited Mr. Albert E. Huber, director of the Indiana Traffic Safety Council and Dr. Robert Yoho, Indiana State Board of Health, to participate in discussions.

Dr. Yoho was invited because of his involvement in emergency medical services planning for Indiana and the implications such planning have in the area of driver education, uniform traffic signs, the implied consent law and other areas which are inter-related in Indiana's total traffic problem.

Mr. Huber pointed out several problem areas in the area of traffic safety, licensure and enforcement including: 1) the lack of an agreement among the medical profession on procedures in disqualifying a person for renewal of license; 2) breakdown in effectiveness of courts due, in part, to political patronage system; 3) police officers compelled to testify during off duty hours, for which they receive no pay and are often unavailable.

As a result of these discussions it was moved by the commission to recommend to the Board of Trustees that ISMA membership become more directly involved in the work of the Indiana Traffic Safety Council; to reactivate the Committee on Medical Aspects of Driver Licensure and to recommend further to the Board of Trustees that ISMA assist the Indiana Traffic Safety Council with at least a token financial contribution.

The commission also moved that Dr. Yoho's report be presented to the Board of Trustees of the association prior to submission to the House of Delegates.

During the year the commission also went on record as recognizing that a drug abuse problem does exist in Indiana. The commission further urged county medical societies to establish study groups on drug abuse and that these study groups coordinate and cooperate with local law enforcement agencies and educational systems in order that more effective programs be formulated for solving this problem.

To substantiate the expression of the commission, Mr. Willis A. Roose, Chief, Drug Section, Indiana State Board of Health, met with the commission and revealed factual data and information on the problem in Indiana.

Mr. Roose advised the commission that by state statute, schools are required to offer drug education to all students in grades four through eight, and it is further mandatory that all schools provide drug education courses in grades nine through twelve. The courses offered in the latter grades are elective.

The commission went on record urging that a definite effort be made by ISMA to advise local medical societies of these facts; that local societies encourage local school superintendents to implement this law, effectively, and urged that local medical societies further offer physician participation in such programs.

The commission also reviewed the law regarding the testing of all teaching personnel, and called to the attention of the Board of Trustees the existence of the law regarding tuberculin testing and chest x-rays with the recommendation that the law be distributed to all physicians in Indiana urging them to follow up all positive tests and chest x-rays.

The commission also considered the matter of reporting by private and other laboratories on venereal disease tests and endorsed the proposal that legislation be enacted by the state of Indiana requiring such reporting.

The commission further went on record as supporting the bill in the 1969 state legislature which would serve to strengthen local health departments through financial assistance.

Sex education in the Indiana public school system was given lengthy consideration by the commission. Harold Negley, representing Superintendent Wells of the State Department of Public Instruction, was invited to attend a session of the commission to enlighten the commission on current sex instruction in schools. Also present for this meeting was Dr. Robert Yoho, Indiana State Board of Health, through whose division such education is coordinated in Indiana.

As a result of these in-depth discussions and extensive research in the area by the chairman of the commission, the commission is presenting to the House of Delegates, the following report, entitled "Sex Education, Family Planning and the Federal Government" as a part of the report of the commission, and is also submitting to the House a resolution on sex education in the Indiana school system.

ROY L. FULTZ, M.D., *Chairman*
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WM. B. SIGMUND, M.D.
CLEON M. SCHAUWECKER, M.D.
WILSON L. DALTON, M.D.
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PAUL SPARKS, M.D.
WYANT J. SHIVELY, M.D.
EARLE U. ROBINSON, JR., M.D.

SIECUS, SEX EDUCATION, FAMILY PLANNING, AND THE FEDERAL GOVERNMENT

In the June 16, 1969 issue of *The Indianapolis Star*, p. 18, there appeared an article by Russell Kirk under the headline, "Teaching About Sex: A Burning Issue." The same article appeared on p. 10 of the June 28, 1969 issue of *Human Events* under the title, "Sex Education in Schools Becomes a Nationwide Issue." This to me was an interesting article. I was extremely gratified to learn of his emphasis on retaining religious and moral concepts and parent involvement in any instructional courses concerning human reproduction. I was even more gratified to learn that the California Board of Education had declared

that "sex education" materials from SIECUS (Sex Information and Education Council of the U.S.) should be eliminated from public schools and that Mr. Kirk concurs with this declaration. Two paragraphs later, however, Mr. Kirk's statements become very confusing and disturbing when he writes,

> "In spite of this (SIECUS) organization's imposing name it has no connection *whatever* with the Federal government, *nor* any subsidy from public funds. For the most part, SIECUS is an offshoot of a little eccentric group called the American Humanist Association . . . ."

My confusion is because I assumed that a writer like Mr. Kirk with the reputation of being a political conservative would have the knowledge to avoid such ambiguity. My being disturbed is due to the fact that I had always felt that writers of the caliber of Mr. Kirk would adequately research their published works in order that their readers always receive the full truth.

Mr. Kirk is not alone in his inadvertant (I hope) misinformation. On the editorial page of *The Indianapolis News* July 10, 1969, the column of Robert S. Allen and John A. Goldsmith refers to SIECUS as "independent" and "non-government." Their column begins by saying:

> "Some members of the House and Senate are being fervently urged to act, but it looks as if Congress will steer carefully clear of the burgeoning public controversy over sex education in schools."

And I would predict that members of Congress would be well advised to "steer carefully clear" of the "controversy over sex education in schools" if their knowledge of the relationship between SIECUS, government, and sex education in the schools is no more complete or accurate than that displayed by columnists Kirk, Allen and Goldsmith. I would further predict that members of the House and Senate would be even better advised to familiarize themselves with the legislation already in effect (and for which many of them voted) that provides for establishment of programs of sex education in our schools.

In order to keep SIECUS in proper perspective, I submit that: 1) SIECUS *does* have connection with the Federal government; 2) SIECUS *does* have connection with subsidy from public funds; 3) SIECUS itself is quite small in terms of numbers of members; but its influence and ramifications seem to be out of proportion to its numbers; 95 is the total aggregate number of the persons who have and/or are serving on the board of directors (this number includes the eight currently listed administrative staff members); and according to the current *SIECUS General Information pamphlet*, "In every sense of the word the directors *are* (my emphasis) SIECUS,"; and 4) if The American Humanist Association is the predecessor of SIECUS as implied by Mr. Kirk, its membership numbers 6,000 as listed on p. 476 of the 1969 *World Almanac;* therefore, I believe this would remove it from the category of "little."

The remainder of this article will primarily involve further elaboration on some of the preceding enumerated points. As stated in Mr. Kirk's article,

> ". . .SIECUS tries to impart a 'new morality' that would be anathema to the great majority of parents and responsible citizens in any community."

With this I heartily agree and further suggest that evidence available points strongly toward an effort by SIECUS members to change attitudes of the professions and the public in general. The same emphasis on "changing attitudes" is made by administrative personnel in the governmental departments with which SIECUS members have connection that is demonstrable.

That SIECUS has a connection with the Federal government can be shown simply by examining the membership roster of the board of directors of SIECUS which is listed in each *SIECUS Newsletter*. Other sources which show some of these connections are publications from the U.S. Government Printing Office that have been prepared for various departments of government. Some of these relationships are evident in the listing below:

Mary I. Bunting, Ph.D., president of Radcliffe College, in the 1966 *SIECUS Newsletter* is listed as a member of the board of directors of SIECUS. The U.S. Government Organization Manual 1966-67 on p. 481 lists her as a member of the National Science Board of the National Science Foundation. On p. 639 of the March 1969 *Congressional Directory* Dr. Bunting continues to be listed the same.

Mary S. Calderone, M.D., executive director of SIECUS, serves as an advisor to the staff of the President's Committee on Population and Family Planning—p. 7, *Report of the President's Committee on Population and Family Planning*, November 1968, and released by U.S. Department of Health, Education and Welfare. This is also stated by Calderone in the *SIECUS Annual Report* 1967-68.

Catherine S. Chilman, Ph.D., in the June 1968 *SIECUS Newsletter* is listed as a member of the board and as Chief, Research Utilization and Development Branch, Office of the Commissioner, Welfare Administration, U.S. Dept. HEW.

Augusto Esquibel, M.D., is listed in the February 1969 *SIECUS Newsletter* as a member of its board and as Special Assistant to the Director for International Activities, National Institute of Mental Health (NIMH). NIMH is a subdivision of the U.S. Dept. of HEW (p. 355, *U.S. Government Organization Manual* 1968-69).

Elizabeth D. Koontz in the June 1968 *SIECUS Newsletter* is listed as a member of the board of directors and as President, National Education Association. On p. 554 of the March 1969 *Congressional Directory* she is listed as Director, Women's Bureau, U.S. Dept. of Labor.

E. James Lieberman, M.D., psychiatrist, in the June 1968 *SIECUS Newsletter* is listed as a board member and as Chief, Center for Child and Family Mental Health, National Institute of Mental Health, a subdivision of the U.S. Dept. of HEW. The March 1969 *Congressional Directory* on p. 569 lists Dr. Lieberman as Associate Director for Audio-visual-Telecommunications, National Library of Medicine, National Institute of Health (NIH). NIH is also a subdivision of the Dept. of HEW—(*U. S. Government Organization Manual* 1968-69).

William G. Saltonstall is listed in the *SIECUS Newsletter*, June 1968 and February, 1969, as a member of the board of SIECUS. In addition the 1968 newsletters list him as an affiliate of the Rodman Job Corps Center, New Bedford, Mass. On p. 63, *U.S. Government Organization Manual*, 1968-69, it is explained that Job Corps Centers are under supervision of the Office of Economic Opportunity, a Federal agency. The February 1969 *SIECUS Newsletter* also lists him as Curator, Alfred North Whitehead Fellowships, Harvard University.

Preston Valien, Ph.D., in 1965 *SIECUS Newsletters* is listed as a member of the board of directors and as Chief of Program Analysis Branch, Division of Graduate Academic Facilities, Office of Education. The March 1969 *Congressional Directory*, p. 570, shows that Valien's title now is Associate Commissioner for the Bureau of Higher Education, Office of Education. The latter is a subdivision of the U. S. Dept. of HEW.

Bennetta B. Washington, Ph.D., in the *SIECUS Newsletter* of 1968 and February, 1969, is listed as Director, Women's Centers Job Corps, Washington, D. C. As previously noted, any Job

Corps is a division of The Office of Economic Opportunity.

Please note that all the above named persons are or have been recently *directly* connected with some major department of government; all are now or have been members of the board of directors of SIECUS. The *SIECUS General Information* folder for 1968-69 states: "In every sense of the word the directors are SIECUS." This folder points out further that, "ALL SIECUS Study Guides are subject to review and acceptance by the *entire* (my emphasis) Board of Directors." Dr. Calderone, executive director of SIECUS, in the August 1968 issue of *Medical Aspects of Human Sexuality* states on p. 40, "THE MEMBERS OF THE BOARD SPEAK FOR SIECUS as a group . . . ." In the Summer, 1965, *SIECUS Newsletter* Dr. Calderone writes, "The SIECUS Board and Executive Committee have met often and actively, and have assumed full responsibility for programs and policies."

In what has been presented thus far we see involvement of the following departments with SIECUS: 1) Population and Family Planning (HEW); 2) National Institute of Mental Health, Division of International Activities (HEW); 3) Women's Bureau (U.S. Dept. of Labor); 4) Child and Family Mental Health (HEW); 5) National Institute of Health, Library of Medicine (HEW); 6) Job Corps (OEO); and the Office of Education (HEW). This is only a partial listing of the ramifications. My *Funk and Wagnalls Dictionary* defines *subsidy* as "pecuniary aid *directly granted by government* to an individual or private commercial enterprise deemed beneficial to the public." *Fund* is defined as "a sum of money or its equivalent reserved for a specific purpose; or money readily available." *Public* refers to "pertaining to, or affecting the people at large or the community."

Public funds, therefore, may be sums of money reserved for a specific purpose affecting the people at large. Each year the President of the United States presents his budget message to Congress in which is included the cost of operation of various departments of government. The Department of HEW, the OEO, and the Department of Labor (including their respective employees) are considered in that budget. The people that I named above who are listed as governmental departmental officials, it seems to me, are receiving public funds, since our tax dollars provide the cash for the Federal budget. They are now or have been in the recent past, members of the board of directors of SIECUS.

John Money, Ph.D., Associate Professor of Medical Psychology and Pediatrics, Johns Hopkins University, is listed in SIECUS newsletters of 1967 and 1968 as a member of the board of directors of SIECUS. On p. 172, Part I, *Public Health Service Grants and Awards Fiscal Year* 1967 *Funds* there is listed a NIMH Grant No. RO1HD 0032511 to *John Money* of Johns Hopkins University in the amount of $31,775. The project title for which this grant was made is listed as, "Longitudinal and related psychohormonal studies." In the same U. S. Government publication other past or current SIECUS board members who received Federal funds are as follows:

p. 209 *John Rock*
Grant No. RO1HD 00614-0451 $ 1,450.
p. 231 *Frederick J. Margolis*
Grant No. RO1DE 01353-07 29,530.
p. 407 *L. Mastroianni, Jr.*
Grant No. RO6FR 00340-01 131,172.
L. Mastroianni, Jr.
Grant No. RO1HD 01810-02S1 20,957.
L. Mastroianni, Jr.
Grant No. RO1HD 01810-03 54,092.

In 1965 there was copyrighted by The Institute of Sex Research, Inc., which is located at Indiana University, Bloomington, Indiana, a book entitled *Sex Offenders*. The publisher was Harper and Row. The authors were given as Paul Gebhard, John Gagnon, Wardell Pomeroy, and Cornelia Christenson. The Fall 1965 issue of the *SIECUS Newsletter* lists *Wardell Pomeroy* and *Cornelia Christenson* as members of the board of directors of SIECUS. *John Gagnon* is listed in the Winter 1967 *SIECUS Newsletter* as a board member. On page vii of the book *Sex Offenders*, the following acknowledgement is made:

> "The salaries of the individuals participating in the years of time-consuming analysis and writing have been covered by grant monies from the National Institute of Mental Health, U. S. Public Health Service, Grant No. MH 1633."

NIMH and USPHS are both subdivisions of the Dept. of HEW. I am reminded again that SIECUS' own information folder states, "In every sense of the word the directors *are* SIECUS."

The 1967 SIECUS newsletters list *Lester Kirkendall*, Ph.D., as a member of the board of directors. On p. 140 of *Children*, July-August 1967, published by the Children's Bureau, U. S. Dept. of HEW in an article entitled, "*Starting a Sex Education Program*," the authors, *Lester A. Kirkendall* and *Helen M. Cox* have the following statement:

"The Office of Education makes grants to support programs to prepare teachers for sex education programs and to educational institutions and community agencies to start or to improve programs in family life education and sex education, and last year helped SIECUS hold a national meeting."

The Office of Education is a subdivision of the Department of HEW, a Federal agency.

SIECUS and SIECUS board members not only concern themselves with domestic programs. *SIECUS General Information* pamphlet 1968-69 states the following:

> "A Department of International Services is in the process of formation, and a Department for Inter-cultural Services is anticipated."

In the *SIECUS Annual Report* 1967-68, its executive director, Dr. Calderone, states,

> "As one of the member agencies of the American Association for World Health, we shall be privileged to help host WHO's (World Health Organization, a health agency of the United Nations) 21st World Health Assembly in Boston in 1969."

Department of State Publication 8399 released October 1968 entitled, "*U. S. Participation in the UN: Report by the President to the Congress for the year* 1967" has several interesting items concerning WHO and family planning. On p. 103 under the heading, "Population Activities," it is stated that WHO has been a leader for several years in the study of population dynamics and further,

> ". . .WHO conducted in-service training for its staff in the fields of population dynamics, the scientific aspects of fertility regulation, and family planning methods."

On page 125 under the heading, "Role of UNICEF (UN Children's Fund) in Family Planning", is the following:

> "Upon request UNICEF will now assist countries whenever family planning is a part of maternal and child health services. WHO will review and recommend proposals for assistance within this context. Thus UNICEF has now adopted the policy of aid in family planning."

On the preceding page (124) we note the following:

> "In the light of the Board's (UNICEF executive board), approval of directing aid to high priority areas; it was not surprising that it *did not* approve expanding UNICEF operations into two new areas—the control of helminth (worm) infestation in children and the control and treatment of dental disease."

Of additional significance and interest is the financial situation of UNICEF as

stated on p. 126 of the previously named State Department publication:

"The continuing voluntary support of the American public is reflected by the size of the annual check turned over to UNICEF by the U. S. Committee. In 1967 this amounted to about $5.5 million, the proceeds from the Halloween Trick or Treat collection and from the sales of UNICEF greeting cards."

Further evidence of international involvement in family planning is obtainable from Report No. 10, Fall 1968 of the *Victor-Bostrum Fund* for the *International Planned Parenthood Federation.* This fund was, according to the 31-page booklet established to assist the movement foi world population control. On p. 3 it will be noted that the fund will make at least $1.5 million available to the International Planned Parenthood Federation in 1969 and again in 1970.

. . ."the Population Fund in Trust. . . will be financing an increased UN staff in this field."

We are further told here that the President of the World Bank, *Robert S. McNamara,* had recently announced that the Bank would make available information and finance family planning facilities of various countries. The report also stated,

"This year the Congress, which last December had earmarked $35 million of AID (Agency for International Development) funds exclusively for population and family planning, increased the earmarked funds for 1969 to $50 million."

In this same Report No. 10 beginning on p. 16 we read what seems to be loosely referred to as a "debate" between two American "scientists," *Dr. Kingsley Davis,* Professor of Sociology, Director of International Population and Urban Research, University of California at Berkeley and *William McElroy,* Chairman, Department of Biology, Johns Hopkins University and President, American Institute of Biological Sciences. The debate is, "Will Family Planning Solve the Population Problem?" This debate, of course, concerns itself with world population control. In reality both men seem to be concerning themselves more with controlling the world's population than with population control of the world.

Dr. Davis in his discussion makes the point thusly,

". . .with traditional morality sponsoring familism, and with prosperity and group power viewed as functions of population growth, suggestions of effective anti-natalist policies evoke ridicule, out rage, or worse."

He points out that *indirect* measures would be thought of first; that is,

"measures that leave people free to make their own reproductive decisions."

". . . one hopes that compulsory measures will not become necessary. It can be argued that over reproduction . . .that is the bearing of more than four children. . . is a worse crime than most and should be outlawed."

". . .The *sine quo non* of a population policy is that people be induced to curb their reproduction to the extent necessary for the collective interest."

The remarks of Dr. McElroy offer very little that is basically different from a collectivist standpoint:

". . .one of the first things that could be initiated immediately is alternation of the abortion laws state by state or even nationally so as to liberalize and promote free abortions."

"there have been a number of interesting incentive suggestions that might be made part of a national policy which would encourage a reduction in the size of the family group. In a positive way, the Federal government, for example, could pay a fee to a couple if they delayed their marriage beyond a given age. For example, if they did not marry until they were 24, they would receive a $500 fee from the government: if they waited until they were 30, they might even get a $4,000 or $5,000 fee. In this way one would tend to reduce family size."

Keep in mind that the above quotes were from a report of a fund-raising arm of Planned Parenthood-World Population (formerly Planned Parenthood Federation of America, Inc.), the U.S. member of International Planned Parenthood Federation. Listed as a council member of Planned Parenthood-World Population is, *John Rock, M.D.,* former SIECUS board member. *Mary S. Calderone,* M.D., executive director of SIECUS, was for 11 years (her statement) Medical Director of Planned Parenthood-World Population. Part 3 of *Population Crisis,* a report of the Senate Committee on Government Operations dated Feb. 1, 1968 on pp. 529, 530, and 531 lists some of the chief recipients of funds from the Agency for International Development (AID). Among those receiving millions of dollars in 1968 was the *International Planned Parenthood Federation.* AID is a Federal agency.

The SIECUS Organization

Most of the material to follow has been obtained from publications of the organization itself, chiefly pamphlets and newsletters.

The organization, SIECUS, was formed in April 1964 and its first newsletter, Vol. No. 1, is dated February, 1965. According to its general information pamphlet "printed 1968-69", its board of directors consists of 50 people each serving three year terms. The executive director seems to be permanent and is *Mary S. Calderone,* M.D. Each director serves voluntarily and without pay, as an individual, "not as representatives of their organizations or institutions." Under this shelter then, they are free to express their views and recommendations in the name of SIECUS while being on the payroll of some institution, usually educational, or a government subsidy or agency. However, the booklet states, "*In every sense of the word the directors are SIECUS*", and that, "ALL SIECUS Study Guides are subject to review and *acceptance* by the *entire* SIECUS board of directors." (emphasis is mine).

The booklet further states,

"Its (SIECUS') especially prepared study guides on many difficult subjects such as homosexuality and masturbation *carry the authority of the entire SIECUS board of directors* and have enjoyed wide distribution." (emphasis mine).

The Summer 1965 *SIECUS Newsletter* states:

"The SIECUS Board and Executive Committe have met often and actively and have assumed full responsibility for programs and policy."

The membership of the board is an impressive array of professionals and includes educators, psychiatrists, pediatricians, gynecologists, sociologists, clergy, publishers, marriage counselors, and lawyers. By SIECUS' own count "19 are Ph.D's and 11 are M.D.'s." In the August 1968 issue of *Medical Aspects of Human Sexuality* Dr. Calderone states,

"The six of us who formed SIECUS in 1964 were an educator in public health, a sociologist, a Protestant clergyman, a lawyer, a family life educator, and myself. . . .SIECUS was formed in the pattern usual for voluntary health organizations, with a board to direct its programs and set policy and an executive director and supporting staff to carry them out."

Because of the impressive backgrounds, positions, and titles of SIECUS board members, their utterances are more apt to be received by the average American as the ultimate authority in sex education, especially when appearing under the banner of the Sex Information and Education Council of the U. S., Inc. Attention by members of the organization seems to focus on "changing attitudes" of individuals and society. Their stated aims and purposes in

their general information folder seem to be multiple but connote preoccupation with sex. It states that the SIECUS purpose is "To establish man's sexuality as a health entity." This seems to be the chief SIECUS slogan and usually appears on the front of every newsletter and somewhere on most SIECUS materials. This slogan deserves careful analysis.

Funk & Wagnalls College Dictionary defines *sexuality* as: "1) the state of being distinguished by sex; 2) preoccupation with sex; and 3) possession of sexual power." The same source defines *entity* as: "1) something existing objectively or in the mind and 2) existence as opposed to non-existence; being."

Which combination of those definitions does SIECUS utilize in providing meaning to its slogan? An examination of further stated purposes and aims in the general information pamphlet might be helpful. Consider the following aims and purposes as expressed by SIECUS:

". . .to give leadership to professionals and to society, to the end that human beings may be aided towards responsible use of the sexual faculty and towards assimilation of sex into their individual life patterns as a creative and re-creative force."

". . . Its (SIECUS) primary aim is to open the doors to dialogue about human sexuality: What it is to be a man or a woman in today's society."

"The major purpose of SIECUS is to promote responsible sex relations. This involves the relationships between male and female (my question—why not man and wife?) in all aspects of human behavior. . . ."

". . .Sex education does not attempt as its major goal to decrease VD or out-of-wedlock pregnancies."

We would expect the organization SIECUS by its very name to focus attention on the subject of sex; however, the intensity and zeal of its executive director and some of its staff and board members would suggest that their use of "sexuality" conforms to the dictionary definition of "preoccupation with sex." That their intent is to change *attitudes* of the average citizen and especially youth through sex education in the schools becomes suggestive on examining some of the statements of SIECUS personnel. Some of these people in their utterances shun the moral concepts of our Judeo-Christian culture as they relate to sex education.

It is of significance, I think, that there seems to be in some of their suggestions and recommendations the connotation of their desire or intent to change the attitudes of professional people and community leaders toward sex and sex education. These professional people and community leaders with changed attitudes would then be expected to help change attitudes of others in order to initiate or propagate sex education programs in school systems, especially those programs outlined by the SIECUS oriented "advisors." If the professions and community leaders choose not to permit their attitudes to be changed their silence on the matter is welcomed; however, any hint of opposition to the current SIECUS thrust by use of logic or exposure to truth is apt to bring forth a tirade of vilification that the unsuspecting public must accept with no ultimate choice but to label that person who opposes the SIECUS brand of sex education a "reactionary", an "ultra-rightist," or a part of a "small vocal minority."

Let's examine some of the ideas expressed by SIECUS personnel. Following are a few choice remarks made by *Mary S. Calderone*, M.D. in October, 1963 in San Francisco, California, where she delivered an address to an audience of the Tenth Annual Meeting of the Academy of Psychosomatic Medicine from which the following remarks are excerpted:

"It is in the sweep of these times that sexual freedom is here to stay. The word *freedom*, is not really applicable, however, implying as it does some sort of orderly sense of *responsibility*."

By way of recommendations she stated:

"I believe we owe our young people and ourselves the following:

"1. Full recognition of man's sexuality as an important health entity, a most vital faculty, no longer to be downgraded but to be dignified by openness, respect, scientific research, understanding and protection. . . .

"2. Full knowledge, not only about human reproduction, but about human sexuality as a health entity. *In the younger years* the reproductive function should be fully taught and explained, and adolescents should receive full information on *sexual functions and attitudes* from teachers skilled in this vital mission. . . .

"3. Full guidance for each individual for the constructive development and integration into his total life pattern of his own sexual potential. It isn't just a matter of teaching facts, we *must teach attitudes*. . . .

"4. Full separation, in our research and our teaching, of the reproductive and sexual functions of sex. We are approaching this concept in the developing science of the regulation of fertility. But we will have to go much farther: with rapidly emerging recognition that the average family from here on in *will have to limit itself to two children*, and with the marriage age as low as it is, we are faced with an infinite number of marriages in the world in which the reproductive function will have to be controlled while one or both of the partners may still be in the early twenties.

"In conclusion, I would submit to you that the day of click-clicking the tongue and shaking the head is or should be long, long past, as is the day of control by guilt, fear or by such words as 'duty, sacredness, ethical, ideals,' which today hold little meaningfulness for many young people. . . ."

Dr. Calderone then mentions briefly a program toward developing her ideas of man's sexuality:

". . .It would take purely and solely as its sphere of interest that area of man's life that is distinguished by the greatest lack of knowledge and the most lurid distortions since the era when medieval mapmakers drew pictures of the world as they imagined it: his own sexuality. It would serve as clearing house, sounding board, *interpreter* and *leader* for sex information and education *—for the professions* and for the *general public*. . . .

"Meanwhile we of the small group I mentioned shall want to look to such people as yourselves for the kind of understanding and support that will allow us to develop a meaningful and dynamic program as rapidly as possible."

In the 1967-68 *SIECUS Annual Report* Dr. Calderone stated:

"As an information and education agency, SIECUS has directed its efforts to three main groups: *professional* and *community* organizations and the *academic* community."

In this same report she boasts of the extent of the areas of influence of SIECUS:

"As one of the member agencies of the *American Association for World Health*, we shall be privileged to help host *WHO's* 21st *World Health Assembly* in Boston in 1969.

"There is SIECUS board representation on the Task Force assigned to plan the Fifth National Convention of the *American College Health Assoc.* in 1970. A board member represents SIECUS on the council of *National Organizations for Children and Youth* . . . has representation on the *American Academy of Obstetricians and Gynecologists'* Liaison Committee on Family Life Education

. . . . I am continuing to represent SIECUS with the Commission on Marriage and Family of the *National Council of Churches*, and as an advisor for one of the panels of the *President's Committee on Population and Family Planning*. . . ."

In the August, 1968 issue of *Medical Aspects of Human Sexuality*, a monthly medical journal, Dr. Calderone is interviewed by *Dr. Harold Lief*. We are told that Dr. Calderone is executive director of SIECUS; but we are not told that Dr. Lief at that time was a vice-president of SIECUS. Dr. Lief became president of SIECUS in January 1969. Following are some statements made by Dr. Calderone in this interview: (emphasis by *italics* is mine).

"SIECUS' role with the general public is as a voluntary health organization, educating about sex *attitudes* and behavior. . . .

"One contribution that SIECUS may make to the practicing *physician* is to stimulate support by his community of his efforts *on behalf of sex education*. . . .

". . . I have published in medical journals . . . just as you have done in the *Journal of the American Medical Association*. . . . In this way we *sensitize physicians*, their *organizations*, as well as the *community*, to what we are beginning to call *education for sexuality* rather than sex education.

". . .Education for sexuality has a much broader connotation. . .it means education for the total person, the whole person, as man or as woman. . . .

". . .No community program can succeed unless it has the understanding and support of *key professional elements* in the community, of which one is certainly the *medical profession*. . . . They can help in content, but the people *to formulate the curriculum* itself are the educator who can call on physicians, psychiatrists, and sociologists as specialists. . . .

". . . Physicians are in key positions to help their patients in acceptance of *every person as a sexual person, at every age*."

The foregoing statements, it seems to me, leave little doubt as to the role the SIECUS director has designed for the physician in promoting her program of "sexuality."

In the same interview Dr. Calderone provides *her* definition of "sexuality" thusly:

"Lots of people ask, 'What do you mean by sexuality?' The dictionary definitions are very unsatisfactory, and don't give it the broad meaning that SIECUS has given it. . . . I look upon sexuality as *everything that has to do with your being a man or being a woman.* Therefore education for sexuality is *every experience you have had up to your particular stage of development as a male or as a female.* (emphasis is Dr. Calderone's).

". . .Maybe one way of putting it is that what I am really trying to do is make sexuality an affirmative way of life for people. I am trying to help people free themselves so that they can express themselves sexually in many, many different ways. . . . It is really a way of life, for we deal with each other as the sexual people we are in all of our relationships with each other."

It is not only Calderone who seems interested in changing "attitudes." Members of the administrative staff expressed some of their own ideas in the SIECUS *Annual Report* 1967-68, *Lester Doniger*, then SIECUS president made the following comments:

"One measure of success is the now almost universal adoption of the term 'human sexuality' to denote the total concept that SIECUS has sought to establish in the public and professional press.

". . .It will be important to determine what is appropriate sex education in the earliest years, beginning with preschool and kindergarten, in relation to desired *sexual attitudes* and behavior in older years, if our goal is to be sound sex education.

". . . the adults in our culture. . . . One such service to this group might be seminars for business executives. . . . The emphasis would be on sex information and education, not on therapy, and the purpose would be to *sensitize* management to sexual problems in business life with exploration of resources for help.

"The opinion-and policy-makers, aided by the mass media in an increasingly fluid culture, have untold power to help. It must be a central task of SIECUS to try to orient these to the stake they have in better *social attitudes* about sex. . . ."

The role that members of the "helping professions" can play in *shaping the sexual attitudes* of the future is likely to be of central importance."

Frances Breed, SIECUS associate director of community services made these points:

". . .SIECUS' concept of Community Services was developed: *to sensitize the public* to the need for understanding the fundamental factors of human sexuality. . . to help the school interpret its role in sex education to the adult public; to aid the churches with supplementary material for their teaching of values relating to sexual behavior.

"Two patterns of community action . . .by SIECUS: 1. Work with community councils. . .planning major public meetings and workshops to broaden understanding of sex education; 2. Consultation over an extended period of time between the community group and SIECUS, helping to *promote local support for sex education programs*" (my emphasis).

Esther D. Schulz, Ph.D., SIECUS associate director of educational services pointed up the role of the teacher in the scheme of things in this same SIECUS report:

"The predominant thrust during 1967-68 was teacher preparation in the area of human sexuality . . . .

"*Teacher readiness* is defined as that point when the instructor is able to transmit sex information in an unbiased manner.

"Our role as consultant is to aid in interpreting content; to suggest a range of educational materials for human sexuality from which a school can make appropriate choices; to outline the theoretical background advisable for teachers. . .and such classroom dynamics as role playing and group discussion.

A future activity of great importance will be to attempt *to develop standards for evaluation* of current sex education programs in schools. . .an important adjunct to this project is assessment and *evaluation of teacher* preparation programs. *This project has already been initiated*" (my emphasis).

The *SIECUS Annual Report* 1967-68 further points out that,

"Major grant support has come from The *Commonwealth* Fund, The *Ford* Foundation, *Kimberly-Clark* Foundation, and the *Public Welfare Foundation, Inc.*"

All contributions to SIECUS are deductible for purposes of income taxes.

In the Winter 1968 *SIECUS Newsletter*, the heading of p. 11 begins:

"FUNDING FOR PROJECTS ON FAMILY LIFE AND SEX EDUCATION available and granted under specific eligibility standards by the following *ongoing programs* of the Office of Education, United States Department of Health, Education and Welfare. (Unless otherwise noted, address is Office of Education, 400 Maryland Avenue, SW, Washington, D.C. 20202)."

Nine different offices or programs are then listed, all of which are directly related to the U.S. Office of Education. In at least one instance that I know of, inquiry was sent to one of the above mentioned offices requesting information on funding of a program of sex education. Among the materials received as a result of this inquiry was a booklet entitled, "Two Articles on Family Life and Sex Education", reprinted from the July-August 1967 issue of *Children*, a magazine published six times yearly by *The Children's Bureau*, U.S. Dept. of Health, Education and Welfare. One of the articles was co-authored by a founder and board member of SIECUS, *Lester A. Kirkendall*. Even though these articles may not represent the policies of The Children's Bureau on sex education, they do reflect the ideas of those people who are working closely with those who establish policy. Following are excerpts from article No. 1, "Helping Children Grow Up Sexually", by *Eleanor Braun Luckey*. Luckey's biographical note states that she has a Ph.D. in psychology from the University of Minnesota, is 1) head of the Department of Child Development and Family Relations, University of Connecticut; 2) is a special consultant to the Children's Bureau on family life education; and 3) is on the executive committee of the National Council on Family Relations. I believe that the emphasis on changing "value systems" and "attitudes" is apparent in some of the quotes which follow that were taken from this article by Luckey

". . .programs of sex education (are) . . .sometimes called family life education, boy-girl relationships, or interpresonal development.

". . .the goals of sex education are not altogether clear. Nor is it clear just whose responsibility it is to give sex information to children and adolescents and to try to *shape the attitudes* that determine their moral values and sexual behavior.

"In any culture, what is 'normal' depends upon the practices of the majority. Many behavior patterns that are quite objectionable in our society are sanctioned in others; for example, homosexual practices, sexual relationships between children, premarital sexual promiscuity, and wife swapping and borrowing are approved forms of behavior in some societies. It is not possible to speak of what is or is not 'normal' unless we specify the society to which we refer.

. "Even *in this country* alone the wide *range of sexual behavior and values* existing today *make 'the norm' impossible to define.*

"*Sexual maturity* rather than sexual normality may be a *better goal for sex education.*

"What is immoral in today's society may be moral in tomorrow's. And what is right for today's generation of young people may be wrong for a generation to come.

"One way to avoid getting hopelessly involved in dilemmas is to go . . . to a *broader concept of morality*, one based on the use of self and one's personal freedom for the benefit of others.

"Unfortunately, our culture has for a long time treated a sexual relationship as a special and separate part of personal and social relationships rather than a normal, natural use of self in relating meaningfully to a person of the opposite sex.

". . .the real goal of any program must be to help in the total development of young people so that they will become the kind of secure persons described above.

". . .the person who works professionally with young people can take a number of steps toward furthering a program of education that will make for mature sexual behavior in our society.

"1. He can help other professional workers define their values and learn how to convey them to others. One of the most helpful tools. . .is the *sensitivity group*, sometimes called the *T-group* . . . the group is designed to encourage its members to *interact in such a way* that insight and self-understanding develop. . . .

"2. He can take part in *inservice training sessions*, workshops, and institutes that provide. . .opportunity to clarify their own *attitudes* for themselves. . . .

"3. He can focus much of his educational efforts on parents. . .the parental influence is so constant and so intense, what parents believe, what they convey, and what they know are crucial influences in the development of the child's *sexual attitudes.*

"Parents, however, often have uncertainties and fears about their own sexuality . . . .

"Thus many parents might benefit from the same kind of *sensitivity group* suggested for professional persons."

A second article in this reprint from *Children* from the Department of HEW is by *Lester A. Kirkendall*, Ph.D., founder and board member of SIECUS and Helen M. Cox. Following are excerpts from that article entitled, "Starting a Sex Education Program":

". . .any school, any community is fully warranted in saying that it is 'expanding and improving' rather than 'starting' a sex education program.

". . .We need a broader idea of sex education. . .such as that offered by the Sex Information and Education Council of the U.S. (SIECUS), an interdisciplinary organization founded in 1964 to '*establish man's sexuality as a health entity*' and 'to dignify it by openness of approach, study, and scientific research.'

"*We do not favor asking parents to decide whether their children may attend a sex education program.* Such a policy implies fear and uncertainty in school authorities and brands sex education as something 'different.'

". . .*effective teachers for sex educatoin programs may come from any field*; they may be men or women, married or single, parents or childless.

"Several Federal agencies have been giving active support for some time to programs preparing young people for marriage and family living. The Public Health Service, (a division of HEW) in its regional conferences, has been urging the schools to offer sex education. The *Office of Education* makes grants to support programs to prepare teachers for sex education programs and to educational institutions and community agencies to start or to improve programs in family life education and sex education, *and last year helped SIECUS hold a national meeting*" (my emphasis).

SIECUS Newsletter, Summer 1967, concerns itself with "teacher preparation" and is written by Esther D. Schulz, Ph. D., Associate Director for Educational Services, SIECUS and *Sally R. Williams*, R.N., M.A., board member of SIECUS. Some of their comments follow:

"Because of the importance of objective classroom discussion about human sexuality, some school districts, on a local basis, and college workshops are including *sensitivity training* as part of teacher preparation. The extent to which teachers can control their biases and permit unrestricted discussion will determine, to a great extent, the continued interest of students.

"The voluminous number of curricula sent to SIECUS for review and assessment shows a strong biological theme or emphasis. Also, inclusion of smoking, venereal disease, alcoholism, drug addiction, and general health practices appears in most curricula. *SIECUS believes these areas should be part of a health education or science curriculum rather than of family life and sex education*" (my emphasis).

Another publication by the Children's

Bureau, U.S. Dept. of HEW is "Selected References for Social Workers on Family Planning." Inside the back cover is the following notation:

"The purpose of this publication is to provide social workers with information useful to them in developing programs for and giving services to families who will be receiving family planning services."

Two of the first three references in this bibliography were authored by *Mary Calderone*, executive director of SIECUS. The commentary on the article by Calderone entitled, "Health Education for Responsible Parenthood", states:

"Until *attitudes* catch up with our new thinking on the responsible use of sex, our programs will not meet the need. The health educator has the job of *changing these attitudes* in the clinic, in the family, and in the community."

The Roles of the Federal Government

Another area that deserves inquiry and examination is the role of the Federal government in sex education programs. Are any such programs proposed, by virtue of what legislation, under whose leadership, and by which governmental departments or agencies? The remaining material from which I quote has all been obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402. Most informative are two documents released by the Dept. of HEW in 1968: 1) *Family Planning: Nationwide Opportunities for Action* and 2) *Population and Family Planning Report of the President's Committee on Population and Family Planning.*"

In the appendix of *Family Planning* is the text of a memorandum by the Secretary of the Department of Health, Education and Welfare addressed to heads of operating agencies concerning family planning policy and is dated Jan. 31, 1968. Significant points made by the secretary are as follows:

"Family planning has been established as *a priority program* within the Department. Each operating agency will utilize its existing authorities to the maximum to promote the development of family planning services.

"Family planning programs conducted or supported by the Department shall guarantee freedom from coercion or pressure of mind or conscience.

"Finally, we must increase public and individual understanding of family life *and sex education.*

"The Deputy Assistant Secretary for Population and Family Planning in the Office of the Assistant Secretary for Health and Scientific Affairs will serve as the focal point for departmental policy and program coordination. . . will cooperate with interested public and private groups; and will issue a statement of actions required to achieve these objectives within the Department" (my emphasis).

In another memorandum on the same date addressed to the same operating agency heads we see the Family Planning Program Objectives outlined in more detail by the Deputy Assistant Secretary for Population and Family Planning. Significant parts are quoted below. Emphasis by italics is mine.

". . . the objectives of family planning programs are to:

* assist parents in attaining and maintaining the family size they desire;
* improve understanding of family life and *human sexuality.*

"SERVICES: Making family planning information and services available and accessible to all in the population who desire and need them.

"TRAINING: Meeting the manpower needs. . . .

"To achieve training objectives, it is necessary:

"To encourage institutions responsible for the professional education of personnel in health, welfare and education fields to include in their curricula, when appropriate, population dynamics, *human sexuality*, fertility regulation and related subjects.

"To support training of social workers, nurses, teachers, clergy, guidance personnel and others in order to aid progress designed to develop further opportunities for *family life and sex education.*

"RESEARCH: Applied research is needed to use . . . in finding ways to promote acceptance of family planning both as a general concept and as a personal commitment.

"To achieve training objectives it is necessary:

"To encourage studies in the behavioral and social sciences of factors which affect *attitudes.* . . .

"PUBLIC EDUCATION AND UNDERSTANDING: Increasing opportunities for *sex education* and public understanding of *family life.*

"To achieve the objectives it is necessary:

"To provide *all young people* with adequate knowledge of human reproduction and information regarding modern scientific advances in the field of *contraception and its meaning* in relation to child spacing and responsible parenthood.

"To assist communities and educational institutions which wish to initiate or improve programs in *family life education* as an integral part of curriculum *from preschool to college and adult levels.*

"To promote family planning information and counseling as an integral part of the services of health and welfare agencies and to encourage the inclusion of family planning and *family life education* in the activities of *youth-serving agencies* and adult education programs.

"*To stimulate appropriate mass media* sion of family planning and *family planning.*

"To study effectiveness of communication among the various *target groups* including the consumer of family planning services."

In the introduction to the booklet, *Family Planning*, it is stated that the *major Federal agency* dealing with family planning activities is the *Department of Health, Education and Welfare;* and that it cooperates with other Federal agencies in reaching special domestic *and foreign publics.* The following recent legislation is given as the avenue through which Federal funds may be utilized in the family planning effort; Child Health Act of 1967; public welfare amendments (1967) to the Social Security Act; 1967 Partnership for Health Amendments to the Public Health Service Act; Title 19, 1965 of the Social Security Act (*Medicaid*); 1967 amendments to the *Elementary and Secondary Education Act of* 1965; and the Comprehensive Health Planning and Health Services Act of 1966. Following are a few of the Federal agencies, departments, or programs that are listed as being involved: The major one—HEW; Department of Defense; Office of Economic Opportunity; Department of Labor; Department of Agriculture; Department of State —Agency for International Development (AID); Department of the Interior; Social and Rehabilitation Service: National Institute of Health; National Institute of Mental Health; Consumer Protection and Environmental Health Service; Department of Housing and Urban Development; and the Model Cities Demonstration Programs.

In order to best demonstrate the scope, significance, and importance of this *family life-sex education-family planning* priority as expressed by this publication prepared by the Dept. of HEW, I am listing a few quotes below:

"In dollar terms, the *greatest potential*

source of Federal support for voluntary organizations, as well as for private physicians who give family planning services, is the Federally aided *Medicaid* program. . . ." p. 9

". . .in a policy statement issued by the Commissioner of Education in 1966. He announced that the *Office of Education 'will support* family life education and *sex education* as an integral part of the curriculum from pre-school to college and adult levels; it will support training for teachers and health and guidance personnel at all levels of instruction. . .and it will support research and development *in all aspects* of family life education and sex education.'" p. 13-14

"One of the results of the Federal aid has been that *all state departments of public instruction now have* one or more persons who are specifically assigned to help local schools with sex education programs." p.14

"Since almost any type of grant made by the Department of Health, Education and Welfare to any type of organization for family planning activities can be used to include a public education component, those applying for such grants may wish to round out their programs by including this aspect in their plan or proposal." p. 15

". . .*Federal aid can support the production* of textbooks, popular and professional publications, films and other *materials needed for sex education* and family planning programs. Production of such materials can also be supported as an element of a broader project." p. 24

"Among the projects being supported by the National Institute of Child Health and Human Development is a study of the effects of intrauterine devices on several species of experimental animals. Studies of the systemic effects of intrauterine devices in women are also receiving support." p. 26

"Studies supported by NIMH grants include an analysis of family planning *attitudes* in a village in *India* and studies of the psychological effects of certain surgical procedures such as *vasectomy* and *therapeutic abortion.*" p. 27

The second document I mentioned previously, *Population and Family Planning*, will be considered. This 43 page booklet released through the Department of HEW is the report of the President's Committee on Population and Family Planning which was appointed by President Johnson July 16, 1968. The report was published in November, 1968.

The committee is chaired by Wilbur J. Cohen, then Secretary of HEW. On pages 6 and 7 of the report are listed the committee members, staff members, and technical advisors. Most of the members of these three groups are employees of some Federal agency; but are mostly in the Department of HEW, the Office of Economic Opportunity, or the Agency for International Development. Two committee members, two staff members, and one technical advisor were officers of the Population Council. *John D. Rockefeller III* is co-chairman of the committee and is chairman of the Board of Trustees of the Population Council. The Population Council is a private organization, reportedly non-profit, created in 1952 and financed primarily by the *Rockefeller Foundation.*

The Ford Foundation is represented by Dr. Oscar Harkavy whose report on *Implementing Department of HEW Policy on Family Planning and Population* begins on p. 163 of Part 1 of hearings on S. 1676, a bill to reorganize the Department of HEW. Recall that it was noted previously in this article that according to Dr. Calderone, the Ford Foundation has been one of the major "funds" to contribute to *SIECUS.*

Planned Parenthood-World Population (formerly Planned Parenthood Federation) has two representatives on the president's committee: Paul H. Todd, Jr., its chief executive officer and Mr. Frederick S. Jaffe as an advisor. *Mary S. Calderone,* M.D., executive director of SIECUS, is also an advisor to the president's committee and was for 11 years a high official (Medical Director) of Planned Parenthood-World Population. *John Rock,* M.D., a former SIECUS board member, is listed as a council member of Planned Parenthood-World Population; and has been noted previously in this report to have been recipient of a direct Federal grant in 1967. PP-WP was previously discussed in relation to its fund raising arm, the *Victor-Bostrum Fund.*

The crux of this committee's report, *Population and Family Planning,* is a number of recommendations to the Federal government concerning policy and priorities. A *five-year policy plan* was outlined for the Dept. of HEW. Major recommendations exclusive of the five-year plan include the following:

1) Family planning is to assume priority status and these services should be made available to all who want them by 1973.

2) The Office of Education should provide significant assistance to appropriate education agencies in development of materials on population and family life.

3) Private organizations and the mass media should be encouraged to expand their efforts to promote public understanding of effects of population trends on family life.

4) The U.S. should increase and expand programs of international assistance in population and family planning.

5) Experienced foreign specialists should be invited to serve on advisory groups for both our domestic and international programs.

6) The Federal government should increase research grants particularly as regards contraceptive methods and programs.

7) The Federal government should establish basic support for population studies centers.

Of most ominous significance is the suggested *five-year plan* for HEW and OEO which would be based on current organizational structure. The plan would provide family planning materials in curricula of *medical* and other schools; expand project grants, formula grants, *Medicaid,* and cash assistance in family planning; a three year training program for Department of HEW personnel in family planning would be implemented. The plan would be supervised by the office of the Deputy Assistant Secretary of Population and Family Planning; and is to be reviewed, approved and/or modified by the Secretary of HEW. *Each year the five-year plan would be updated and one more year added.*

The five-year plan is summarized on p. 41 of the booklet, *Population and Family Planning;* and contains the following: (That portion of the text which is emphasized in the original is in italics).

"Although the five-year basic operating plan will be substantially changed and revised as time goes by, the plan is useful as a tactical mechanism:

"*to force *decisions* on budget, personnel, and operations in accordance with top-level DHEW policy;

"*to provide a means to check *results* against *promises;*

"*to provide a meaningful *power center* at the regional level;

"*to bring the Office of the Deputy Assistant Secretary for Population and Family Planning to bear directly on the *decision process;*

"*to provide a mechanism by which *evaluation results* can help shape program decisions.

"This outline for a basic five-year operating plan for a domestic program is presented in detail as a model suitable for other agencies."

Best we not forget that most of the recommendations of the president's committee were implemented in the document, *Family Planning*, released by HEW and containing the memorandum of the Deputy Assistant Secretary for Population and Family Planning, Katherine B. Oettinger. This memorandum was also approved by Philip R. Lee, M.D., Assistant Secretary for Health and Scientific Affairs.

The naive among us would perhaps surmise at this point that what has just been discussed regarding sex education is only an outline or a proposal for what might come to pass. Let's take another look.

Already in 1969 the U.S. Office of Education, U.S. Department of HEW, released through the U.S. Government Printing Office a publication called, "*Pacesetters Innovation, Fiscal Year* 1968." The stated purpose and use of this document is as follows:

> "Pacesetters in Innovation, Fiscal Year 1968, "presents information on Projects to Advance Creativity in Education (*PACE*) approved during fiscal year 1968. The PACE program is authorized and funded under *TITLE III*, Supplementary Centers and Services, of the Elementary and Secondary Education Act of 1965.
>
> "This volume represents a compilation of planning and *operational* grants."

On p. 69 of the *Subject Index* we note a listing of five separate projects by title, four of which are classified as operational under the heading *Sex Education*. On p. 16 of the "Project Resumes" section is a description of the operational project entitled, "T-V, A New Dimension in Health Instruction." Excerpts from that description are as follows:

> "Calif., Pasadena, unified School District
>
> "Descriptors . . . Community Involvement, Grades 1-6, Grades 7-12, Health Education, Sequential Programs, *Sex Education*, Video Tape Recordings, Alcoholism, Drug Addiction, First Aid, etc.
>
> "A sequential program of health education, using videotaped instructional units, will be offered to all students in an urban area. . . . An understanding of mental health and *man's sexuality* and its influence will be incorporated at every grade level.
>
> "Approximately 41,404 students, Grades 1-12, will be served."

A second operational program described on page 34 contains the following information:

> "Countywide Direction for Family Life Education"
>
> "Descriptors-Articulation (program), curriculum development, *Family Life Education*, Grades 1-6, Grades 7-12, Interagency, coordination, *sex education*, instructional materials.
>
> "A family life and sex education program will be developed for students in an urban/suburban area. A series of articulated instructional units will be formed for Grades K-12. . . .Model programs will be developed for courses of study and will be adapted to the needs of each school. Approximately 140,790 students, Grades K-12 will be served."

A third operational project in its description beginning on p. 59 contains the following:

> "Developing and Implementing a Program That Provides a Basis for Social and Emotional Growth—grades K-8.
>
> "Descriptors: Curriculum Development, Emotional Development, Grades 1-6, Grades 7-12, Group Counseling, *Sex Education*, Social Development, Adolescents, Grouping (instructional purposes), Interdisciplinary approach, Outdoor Education, Parent School Relationship, Parent Workshops, Self Concept, Small Group Instruction.
>
> "*Sex education will be introduced* into the K-8 curriculum for students in a rural area. Emphasis will be placed upon presenting information on human sexuality through an interdisciplinary approach. . . . *Sex information* will be systematically integrated into academic subjects in the regular curriculum. *Special learning situations* will be constructed to facilitate student development in the areas of. . .(1) achievement of sexual identity, (2) skill in the *sex-linked social roles*, and (3) capacity to have meaningful relationships with members of the opposite sex. *Social interaction* in small group situations will be stressed. Adults and children in grades K-5 will be involved in intrinsically interesting/productive activities both in the classroom and out of doors. Both a male and female adult will be present to guide the activities of the groups. Small-group counseling will be offered to sixth, seventh, and eighth grade students. . . . Approximately 698 students, Grades K-12 will be served."

Do these examples leave any doubt as to the intent of the priorities given to the *family life-sex education-family planning* programs outlined by the Department of HEW?

Summary and Conclusions

From what has been presented it seems fairly obvious that there is operational today a relatively young, relatively small "private" organization called SIECUS (Sex Information and Education Council of the U.S.) whose preoccupation is sex and whose intent seems to be the changing of attitudes of the professions and the public toward it. SIECUS' president of 1967, *Lester Doniger*, alluded to this when he stated in the *SIECUS Annual Report* 1967-68:

> "One measure of success is the now almost universal adoption of the term 'human sexuality' to denote the total concept that SIECUS has sought to establish in the public and professional press."

This term we have seen repeatedly in the policy statements and programs outlined by the U.S. Department of HEW.

The members of SIECUS are professionals with impressive titles and degrees. They enjoy positions representative of authority and seem to be accepted authoritarians and experts. Most of the membership, even the M.D.'s, are aligned with what has come to be known as the "behavioral sciences" that are little understood by the average G.P. or the general public. However, I hope that most M.D.'s will see the effort being made to recruit their support for the SIECUS-type of sex education and will not fall victims to such a ruse.

The target of the programs suggested by SIECUS is our youth through the educational process and through the training or "re-training" of teachers who would teach sex education. Dr. Calderone said it in 1963 in San Francisco:

> "*In the younger years* the reproductive function should be fully taught and explained, and adolescents should receive full information on sexual functions and attitudes from teachers skilled in this vital mission . . . . It [alluding to SIECUS which was not yet chartered] would serve as . . . *interpreter* and *leader* for sex information and *education* . . . for the *professions* and the *general public*."

The Federal programs as outlined in the Department of HEW publications are then "on target" with their programs of sex education for grades K through 12; and their "teacher training" programs and sensitivity training techniques.

Youth is the most critical area of the life of any nation. My experience with most of our present youth has been that they are eager to learn and apply what they learn; and their feelings of insecurity result from looking to their peers for guidance in the form of concrete answers, and too many times being refused those answers.

Permanent guidelines of morality are as

ecessary to the total development of a oungster as the basic fixed formulae of hysics are necessary for sending men on round trip to the moon. To deprive youth f these guidelines in their formative years s to deprive them of sound doctrine. Our oung people are deserving of the full enefits of sound doctrine in their pursuit f education and personality development. n fact, it is mandatory to our survival as nation.

To deny youngsters in their educational rocess exposure to Judeo-Christian concepts of morality as they relate to sexual natters is, in my opinion, depriving them f sound doctrine. These concepts are ermanent, quite simple, concise, and clear. he SIECUS purpose is stated as, "To stablish man's sexuality as a health ntity." To examine these phrases in terms f Judeo-Christian morality makes this logan seem very ridiculous: man's sexality *is* established in Genesis 1:27 . . . So God created man in his own image, in ie image of God created he him; *male nd female* created he them."; "as a ealth entity" is confirmed in Genesis 2:18 . . "And the Lord God said, *It is not ood that the man should be alone;* I will ake him an help meet for him."; and the ioral aspect is added further in Genesis :24, 25 . . . "Therefore shall a man ave his father and his mother, and shall leave unto *his wife;* and they shall be ne flesh. And they were both naked, the *an and his wife,* and were not ashamed."

Mr. Average American is being constantly ombarded with the Pavlovian stimuli that e are living in "changing times" in an affluent", "progressive" society; and if e as individuals are to survive comortably (physically and emotionally), ien we must "adjust" to these changes y a "reassessment" of our "value system." f Mr. American doesn't do this, he is d to believe, he will drift out of the mainstream" and the most practical thing or him to do is to change his "attitudes" oward tradition; because he is further led o believe that standards are different now n this new "great society" and "technological age" from what they were in his ay of youth. Mr. American, do not be mis-d by this verbal garbage that the "experts" serve you! Mr. American, do not ust reassess but *resume* assessing constantly; and let your *reason* not your motions prevail. Be realistic!

The realism here is that standards have ot changed; but peoples' conduct relative to standards has changed and subsequently *attitudes* toward those standards ave changed.

The SIECUS people choose to omit ie moral aspects of sexuality from their recommended sex education programs. This is justified according to them on the grounds that this is the responsibility of the home or the church. I maintain that youth is the responsibility of *every* adult who at any time has the opportunity to instruct him in sound doctrine. To condone a morally sterile sex education program is but to contribute to the moral decline of our nation through placing a stamp of approval on amorality for our youth. If the medical profession yields to the demands to change its "attitudes" about sex education and is persuaded by ear-tickling phrases to assist in changing the attitudes of the general public; then it is doomed as a respected profession and would so deserve to be.

With Medicare and Medicaid the same "humanistic" carrot was dangled before the medical profession to persuade them to "go along" for the sake of "these old people"; and "after all, it was the law of the land." We are still smarting from reverberations of the warnings on that one. It is not necessary that the medical profession repeat past mistakes and surrender even more important principles. SIECUS is not the law of the land and to reject its programs and influence *in toto* is a violation of no law.

In conclusion, it might be appropriate to muse on a few thoughts from the Book of Proverbs:

> "A wise man will hear, and will increase learning: and a man of understanding shall attain unto wise counsels."
>
> "The fear of the Lord is the beginning of knowledge: but fools despise wisdom and instruction."

May the medical profession responsibly seek always to act wisely and with knowledge.

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Voluntary Health Agencies

HOUSE ACTION: Adopted.

The organizational meeting of this commission was held on November 17, 1968. Doctor Corcoran, president of ISMA, outlined the goals of this commission for the year and submitted a number of suggestions from the Board of Trustees of the works of this commission. The commission has kept these directives in mind through the entire year and practically all of the suggestions have been carried out. Where suggestions were made that cannot be carried out, those concerned have been given an explanation for the reasons.

The following commission officers were elected: Dr. Wayne Endicott, elected secretary; Dr. M. O. Scamahorn, vice chairman and Dr. Norman Booher, re-elected chairman.

Plans for the year were gone over in detail and liaison appointments to the voluntary agencies operating on the statewide program in Indiana were made. As usual, the commission assigned specific members of the commission to two or more voluntary agencies and these members were charged with the responsibility of becoming familiar with the personnel and policies of these agencies and reporting their views to the commission as a whole. Plans for the remainder of the year were made and reduced to writing.

One of the most important annual projects of this commission is to meet in January with the executives and officers of all the voluntary health agencies with statewide programs in Indiana. This meeting was held in association headquarters on January 19, 1969, and every agency was represented—in most cases by a president and the chief executive officer and in some instances by more representatives. A three hour dialogue was enjoyed between your commission and these individuals and several projects for cooperative action were outlined. One of the main suggestions of these agencies to our association is that we do more to assure the cooperation of physicians throughout the state with the voluntary health agencies. It was also suggested that the cooperative activities of the commission and the agencies should receive as much publicity to the members of the state association as possible. As a result of this recommendation, Mr. Waggener agreed to insert such information in the News Flash from time to time.

The agencies with state programs emphasized the need in their opinion for county societies to have a committee that was actively interested and alert to the work of the voluntary health agencies in their particular areas.

The elimination of duplication was brought up by members of the commission to the agencies and there was some discussion of an Indiana Voluntary Health Council. This was not consummated because of a question of possible duplication in the Comprehensive Health Planning Council.

The intense desire on the part of the voluntary agencies for the placards previously published by this association setting forth the names of the voluntary health agencies that have met the criteria of the ISMA was made evident. The agen-

cies voted to assist in the distribution of these placards in some instances and in some areas to assume the entire responsibility of distribution.

In this joint meeting in January, the joint scientific meeting in cooperation with the Indiana Public Health Association and the Indiana Tuberculosis Association was planned and since the dean of the Indiana University School of Medicine had promised a better audience of students this year than last, it was decided to repeat the program at the medical center to acquaint medical students with the potential resources offered physicians by the voluntary health agencies.

On Wednesday, February 5, a joint committee between the voluntary health agencies and the commission met to plan a program for the April 24th Indiana Public Health Association meeting. An excellent program was planned. The speakers included Dr. G. O. Larson, past president of the association, Mr. Glenn Sample of the Farm Bureau and a member of the Comprehensive Health Planning, Dr. Mark Dyken on "A Unique Approach to a Statewide Locally Oriented Program" and Dr. Merritt Alcorn on "Implementation of the Comprehensive Health Program."

The next meeting of the commission was the attempt to present a program that had been the subject of much effort on the part of all voluntary agencies to the medical students in Indiana University Medical Center. Last year a similar program was attempted and material assembled but less than ten students appeared. For this year's program the dean of the medical school had promised a good audience—nine speakers had prepared a short address from the voluntary agencies, plus remarks from this commission. This was scheduled for 4:00 P.M., March 19, and while all of the speakers and members of this commission who were sheduled for appearances were present, less than twelve medical students attended. This was a great disappointment to all concerned and a matter for many questions.

The biggest program of the year was held on April 24 and was the joint scientific meeting of the Indiana Public Health Association and the Indiana Tuberculosis Association on April 24. The program for this meeting was outlined above. It was very successful and again proved to be most worthwhile, both from a scientific point of view and, especially, from a public relations standpoint. This meeting was preceded by a breakfast for which the medical association was host, at which time the speakers and representatives from the agencies were guests. Following the joint scientific meeting, the commission members attended a joint luncheon with the Indiana Public Health Association, followed by a business meeting occupying most of the afternoon at which routine business was transacted. The commission also had the privilege of a discussion from Dr. Lowell Steen as a liaison officer from the Board of Trustees. At this meeting, the final agencies which were recognized for the current year were determined and the list given to Mr. Kenneth Bush for publication of the placards which were to be done and distributed in May.

At this meeting, the commission discussed plans for their joint meeting with the Council of the AMA on Voluntary Health Agencies to be held in Indianapolis, October 11 and 12, 1969. At the time of the writing of this report only projected plans can be reported. The Council of the AMA will meet the morning of October 11 at the Stouffer Inn and will be joined at 11:00 A.M. by members of the commission of the state medical association for luncheon in the Speedway Motel, after which the two groups will be addressed by Dr. Thomas A. Hanna, chief medical director of the Indianapolis Motor Speedway, following which we will have a very brief tour of the Speedway itself. At 3:30 P.M. the Council of the AMA and the commission of the association will have a joint meeting at the Stouffer Inn and at 7:00 P.M. the ISMA will be the host for dinner at Stouffer Inn for the council and their wives; the assigned staff of the AMA, the president of the AMA and other distinguished guests represented on the regional conference which will embrace 11 states to take place on Sunday, October 12. At this dinner, the members of this commission and the officers of the ISMA will also attend as assistant hosts.

The commission requests the House of Delegates to approve its activities in the past year and would recommend that a similar program be followed in the year to come with the possible exception of any cooperative program with the Indiana University School of Medicine.

The placards are in the process of distribution and it is felt that they should be continued and again this commission recommends that greater effort should be made to bring the work of this association with the voluntary health agencies to the notice of the public. It is felt that a great deal of good public relations would result and that organized medicine of this state would be given credit for an effort that is now unknown to those whose opinion w value.

The commission again cannot expres strongly enough its appreciation to Mr Kenneth Bush, a member of the staf assigned to this commission and to Mis Eleanor Chapple, both of whom hav given enthusiastic assistance to the com mission.

NORMAN R. BOOHER, M.D., *Chairman*
M. O. SCAMAHORN, M.D., *Vice-Chairman*
WAYNE ENDICOTT, M.D., *Secretary*
ALBERT RITZ, M.D.
ROBERT H. RANG, M.D.
T. A. NEATHAMER, M.D.
HARRY R. BAXTER, M.D.
WILLIAM G. BANNON, M.D.
LOWELL W. PAINTER, M.D.
ALBERT E. APPLEGATE, M.D
WALFRED A. NELSON, M.D.
LLOYD L. HILL, M.D.
RICHARD WILLARD, M.D.
FRANK J. MCGUE, M.D.
CHARLES RUSHMORE, M.D.

Medical Economics and Insurance

HOUSE ACTION: Adopted.

The Commission on Medical Economic and Insurance for 1968-1969 is compose of Thomas J. Conway, Terre Haute, chai man; Kenneth O. Neumann, Lafayett vice-chairman; Paul M. Inlow, Shelby ville, secretary; Charles M. Sinn, Evan ville; Paul W. Holtzman, Bloomington; Ed ward J. Ploetner, Jasper; William Scha brough, Ewing; Morris E. Thomas, Indi anapolis; Charles E. Geckler, Muncie; A.S Kobak, Valparaiso; Thomas G. Hamilto Columbia City; Jack W. Hannah, Elkhart Chester A. Stayton, Jr., Indianapolis an Willard Barnhart, Evansville.

Their meetings have underlined the im portance of economics and insurance ma agement in medicine today. Their interes and industry was vigorous and sustained and yet they would all agree that the su face of the many problems confronting th physicians of Indiana was barely scratche

In an effort to make the approach mor comprehensive, four subcommittees wer formed so that more careful scrutiny of few commission members might be given t each issue raised. The subcommittees were (a) Group Insurance Plans for ISM Members; (b) Outpatient Insurance Co erage; (c) Group Practice; and (d Health Insurance Availability.

A meeting with Mr. Oscar Ritz, the I surance Commissioner of the State of Ind ana, helped to determine the feasibility

iany different programs suggested by members of the commission.

The accomplishments and goals will be ummarized briefly. The disability insurnce program for ISMA members was enurged to provide coverage through the ontinental Casualty Company for those iembers not previously eligible for benets for whatever reason. The ready availbility of this disability program to new iembers of the ISMA was confirmed. ttempts are being made to clarify the exent to which outpatient investigative nd treatment procedures should be and ill be covered by most medical insurance lans. The malpractice problem is being tudied intensely. All members of the ISMA iould be aware that the commission may e able to provide a group malpractice overage for all members of the ISMA if sizeable percentage of the membership ill enroll in the program. Other methods f voluntary coverage for membership are eing alternately studied. Suggestions and pinions of the membership on this probem of malpractice insurance coverage ill be greatly appreciated by this comission. The possibility of still other group overages for the membership are not being verlooked and it is hoped they will be resented in one big package when the ialpractice problem is clarified.

The recent legislative move toward allowig physicians to incorporate has made ie future of group practice in Indiana a right one. The possibility that the devery of medical care to Hoosier citizens ight be thereby enhanced makes more nportant this new opportunity for physiians to form professional corporations. The ommission is interested in providing this iformation to the membership and would ppreciate the thoughts of the members on ie choice of a formal presentation at conention time vs. a mailing of particulars.

All-in-all, the plight of the provider and onsumer of medical care in Indiana is eing continually analyzed and changes for ie better will hopefully be provided. The reat expanse of this field in recent years s fascinating and foreboding. The members f this commission certainly can report that nothing else is achieved they are beoming better informed.

THOMAS J. CONWAY, M.D., *Chairman*
KENNETH O. NEUMANN, M.D., *Vice-Chairman*
PAUL M. INLOW, M.D., *Secretary*
CHARLES M. SINN, M.D.
PAUL W. HOLTZMAN, M.D.
EDWARD J. PLOETNER, M.D.
WILLIAM SCHARBROUGH, M.D.
MORRIS E. THOMAS, M.D.
CHARLES E. GECKLER, M.D.
A. S. KOBAK, M.D.
THOMAS G. HAMILTON, M.D.
JACK W. HANNAH, M.D.
CHESTER A. STAYTON, JR., M.D.
WILLARD BARNHART, M.D.

Medical Education and Licensure

HOUSE ACTION: Ordered filed.

The Commission on Medical Education and Licensure has met twice thus far in 1969, the meetings being held on January 26 and May 18.

At our first meeting we were honored to have as guests two members of the Student American Medical Association, Michael D. Cashman and Robert Steel.

Doctor Lukemeyer reported to the commission on the availability of speakers from the Indiana University School of Medicine. Also, under the Indiana Plan, the medical school now has 30 video tape centers and equipment in 15 cities, which are being utilized for postgraduate education. Television stations in Terre Haute, Evansville, Fort Wayne, Lafayette, Elkhart, South Bend, Gary and Muncie will be utilized starting in September for live hospital medical programs for physicians.

The preceptor program continues to be very successful. It is under the direction of Dr. William Ringer of Williamsport. Dr. Ringer has recently reviewed and brought up to date the list of approved preceptors, which now includes 74 physicians. It is the recommendation of this commission that recognition for their efforts be given the preceptors, both in our *Journal* and in the form of individual certificates.

The commission went on record as supporting the State Board of Medical Registration's proposals to increase the licensing examination fee in Indiana to $75 and to give a machine-graded type of examination, replacing the previous hand-graded one.

Discussion has taken place with regard to conducting a survey of medical and paramedical personnel needs in Indiana. However, it is the commission's feeling that this is a large undertaking and should be done by a professional staff.

The commission has wholeheartedly endorsed the Indiana Plan.

Dr. Lowell Steen has requested that the commission compile a list of speakers available for speaking on subjects pertinent to medicine. This is being done at the present time and hopefully will be available soon.

Doctor Irwin reported that the university has started a section of community medicine.

The commission is now studying the reports from the Oregon and California Medical Associations in regard to continuing medical education for physicians, particularly their views toward relicensure and recertification. Discussion will occur at our next meeting.

Dr. Lowell Steen, president-elect of the Indiana State Medical Association, communicated to the commission some of his thoughts. These included physician's attitudes toward learning; the medical audit in continuing education; home study courses; dial access tapes; computer assisted instruction; newer techniques in programmed instruction; live two-way television conferences; and self-assessment programs. We thank Dr. Steen for his interest in and emphasis on continuing medical education.

I wish to thank the commission members for their loyalty and continued support.

JOHN L. CULLISON, M.D., *Chairman*
FRANKLIN BRYAN, M.D., *Vice-Chairman*
BETTY DUKES, M.D., *Secretary*
GILBERT HIMEBAUGH, M.D.
JOHN M. PARIS, M.D.
GEORGE G. MORRISON, JR., M.D.
WAYNE A. CROCKETT, M.D.
FRANK COBLE, M.D.
GEORGE T. LUKEMEYER, M.D.
WILLIAM RINGER, M.D.
LEO RADIGAN, M.D.
LOWELL J. HILLIS, M.D.
JENE R. BENNETT, M.D.
MERRITT O. ALCORN, M.D.
PETER J. PILECKI, M.D.
GLENN W. IRWIN, JR., M.D., *(Ex-Officio)*

Special Activities

HOUSE ACTION: Ordered filed.

The Commission on Special Activities met twice this year. An extensive study into the relations with foreign medical graduates was made during a very informative session spent with Dr. Antonio Donesa of Fort Wayne, Indiana. Dr. Donesa is the secretary for the National Foreign Graduate Association. He advanced the problems and adversities met by the foreign medical graduate in his attempt to practice in the United States and Indiana in particular. He also gave concrete ideas on how to eliminate many of the unfair obstacles and yet maintain the highest standards of medical practice in Indiana.

The commission considered Dr. Donesa's proposals and the changes we felt were warranted were then recommended to Dr. Merritt O. Alcorn, vice president of the State Board of Medical Registration and Examination of Indiana. We were most gratified to find that positive programs and testing methods to rectify many of the inequities have been introduced or will be in the near future. For a further discussion of this work see the minutes of the April 27, 1969 meeting of the Commission on Special Activities.

The commission also started work on a study of the accreditation of hospitals by the Joint Commission on Hospital Accreditation. This is a complex problem and will need to be pursued further in commission meetings next year. Preliminary studies are now under way by commission members, Dr. Ray H. Burnikel of Evansville and Dr. Harold C. Ochsner of Indianapolis.

Dr. William H. Garner, Jr., secretary of the commission, forwarded letters pledging our help to the Commission on Public Information on joint problems and aid to the woman's auxiliary in the consideration of rehabilitation and the auxiliary's renewed interest in encouraging young people to seek a career in the health fields.

The commission also wants the Indiana State Medical Association to have more say in consideration of road and highway safety in this state. Many of the present glaring errors could have been prevented by the active participation of a physician, familiar with these problems, on the State Highway Commission. Therefore, this commission rccommends to the Board of Trustees of the ISMA that an all out effort be made to place such a physician on the Indiana State Highway Commission.

MARVIN E. PRIDDY, M.D., *Chairman*
RAY H. BURNIKEL, M.D., *Vice-Chairman*
WILLIAM H. GARNER, JR., M.D., *Secretary*
JOHN C. LINSON, M.D.
HAROLD C. OCHSNER, M.D.
HENRY BIBLER, M.D.
ADOLPH WALKER, M.D.
EVERETT F. DONNELLY, M.D.
K. G. HILL, M.D.
ROBERT P. ACHER, M.D.
NORBERT WELCH, M.D.
FRED C. POEHLER, M.D.
FRED E. HAGGERTY, M.D.

Aging

HOUSE ACTION: Adopted.

This year the commission took for its theme the concept of "preventive geriatrics." This idea had been touched upon in preceding years but had not been developed. It must be acknowledged here that it still has not been "developed" but is as yet more of a latent image. Actually, it is a needed support in the foundation of "independent living" which has been emphasized for years as a continuing goal for the aging and the aged, not only by this commission, but also by the Indiana State Commission on the Aging and Aged, and by the State Board of Health.

The surface of this field has only been scratched, since it is really more complex than its name, or designation, would indicate. There are many problems of retirement at age 65 in relation to emotional shock, waste of manpower, waste of experience, etc., which are thrust upon society by such an arbitrary policy. These effects are not found in every case, but they do occur in a high percentage of the retired. is likely that many would benefit from mental preparation for retirement some time before the event. This might be considered as a sort of preventive rehabilitation.

As aging proceeds—at unpredictable rates in different individuals—physical changes multiply and assert themselves. If independent living is to continue, these effects must be combatted, and the aging one will need help in caring for his health. Home health care is recognized as offering the greatest rewards, but has received less attention than the more dramatic development of extended hospital care (so-called "Extended Health Facilities"), nursing homes (really, custodial care) and "retirement homes." The development of home health care by such means as home health aides, Homemakers, "meals on wheels", etc., has been quite spotty—well along in some communities, lacking in others. Among its other projects, the commission maintains interest in promoting availability of home health care, not only for the indigent and "medically indigent" but also for those who can afford to pay. Personnel seems gradually to be becoming more available, as witness the fact that the State Board of Health has trained 620 nurses in the elementary principles of rehabilitation. Among these were nurses from 109 nursing homes, but only two county homes participated. Homemakers and home health aides are in short supply in many places. It must be recognized that home health care is not limited to those past a certain age, but by and large the majority of those needing it will be among the elderly.

The commission feels, and wishes to emphasize, that for the maintenance of high standards of care in extended health facilities, in nursing homes and in county homes, no amount of rules and regulations can equal in effectiveness the alert and continued medical supervision of their patients by the physicians of Indiana. The physician must be in control at all times. Dr. A. C. Offutt, State Health Commissioner, states that his experience in dealing with health facilities has been. . "That patient needs are met in those cases in which medical supervision is maintained and the physician-patient relationship is perpetuated as inviolate."

These considerations have led the commission to formulate a resolution to be presented to the House of Delegates, as follows:

WHEREAS, the Commission on Aging of the Indiana State Medical Association exist in many of Indiana's nursing homes and,

WHEREAS, members of the commission have been advised of actual instances of poor administration and substandard care in many nursing homes, which may be due to the necessity of the administration recommending and supervising rehabilitation procedures, and,

WHEREAS, it is evident that in the interest of good medical treatment of older patients, the physician must be primarily involved,

NOW, THEREFORE, BE IT RESOLVED, that members of the Indiana State Medical Association in order to exert greater influence in upgrading facilities and patient care be urged to maintain an active and continuing doctor-patient relationship with patients confined to all medical care facilities in addition to the acute general hospital facilities in the state.

Another impediment to independent living by the retired person on Social Security has been the limitation of earned income, as it inhibits the healthful and enjoyable activity of useful work and promotes a dreary outlook and a feeling of uselessness. Therefore, the commission has formulated another resolution, to be submitted to the House of Delegates, as follows:

WHEREAS, the Commission on Aging of the Indiana State Medical Association has been on record for several years as promoting the goal of independent living for the elderly, as long as they are capable of it, and,

WHEREAS, the limitation on earnings of those receiving Social Security benefits tends to discourage useful and profitable

employment, and,

WHEREAS, this inhibits healthful and enjoyable activity and promotes a negative outlook,

NOW, THEREFORE, BE IT RESOLVED, that the ISMA petition the U.S. Senators and the Congressmen from the state of Indiana to initiate and/or to support the elimination of this impediment to independent living, and,

BE IT FURTHER RESOLVED, that such remedial action be made effective as soon as possible.

This commission met this year at Indianapolis on January 26, March 30 and June 1. Dr. George E. Davis, executive director of the Indiana State Commission on the Aging and Aged, attended two of these meetings, by invitation. His commission is handicapped in that it has no field personnel has considered conditions which presently He feels that education of the general to choose one county for long-term develtf the aged are to enjoy independent living they must be mentally able to do so. It what is going on throughout the state. place from which to work. A plan is afoot like to inject here a philosophical suggestion which should help to maintain a proper perspective: never complain too much of old age—it is a privilege denied care services.

Amid all of these perplexities and problems, your commission chairman would chronically ill and the aged in one group. He too emphasized homemaker and home opment in preventive action, calculated to promote independent living. This pilot study would require personal interviews rather than questionnaires by mail, etc. Also, he cautioned against lumping the to many.

The entire commission joins in thanks to the ISMA Headquarters Office, for their help behind the scenes.

A. W. CAVINS, M.D.,
Chairman

W. R. VAN DEN BOSCH, M.D.,
Vice-Chairman

RAYMOND DUNCAN, M.D.,
Secretary

BERNARD B. ROSENBLATT, M.D.
R. E. BUCKINGHAM, M.D.
JOHN O. BUTLER, M.D.
GEORGE M. YOUNG, M.D.
GEORGE W. WAGONER, M.D.
NATHAN SALON, M.D.
THOMAS A. ELLIOTT, M.D.
ANDREW C. OFFUTT, M.D.
MARVIN E. HAWES, M.D.
JAMES R. GUTHRIE, M.D.
WENDELL C. ANDERSON, M.D.

Emergency Medical Services

HOUSE ACTION: Adopted.

The Commission on Emergency Medical Services was organized in January, 1969, and held subsequent meetings in February, March and May.

Administrative support has been provided by Mr. Kenneth Bush and has been excellent. For the meetings we adopted the dual format of an informational report on particular problems followed by a planning session. By this method it has been possible to advise and inform the members of the commission and simultaneously to begin working toward the commission's goals.

Reports were received from representatives of private and municipal ambulance services, emergency radio communications representatives and emergency telephone system specialists. An entire meeting was devoted to the evolution of a plan for highway directional road signs to emergency medical services.

In April, we held a joint meeting with members of the State Health Planning Council. At their request we made the preliminary selection of community hospitals which should be developed into regional trauma centers. This list is as follows:

Region	1.	Marion County General Hospital, Community Hospital of Indianapolis, Methodist Hospital—Indianapolis
Region	2.	St. Elizabeth's—Lafayette
Region	3.	St. Margaret's—Hammond Methodist Hospital of Gary, LaPorte Hospital
Region	4.	Memorial Hospital of South Bend, Elkhart General Hospital
Region	5.	Lutheran Hospital—Fort Wayne
Region	6.	St. Joseph's Hospital—Kokomo
Region	7.	Grant County Hospital—Marion Ball Memorial Hospital—Muncie
Region	8.	Reid Memorial—Richmond
Region	9.	University Hospital—Cincinnati
Region	10.	Bartholomew County—Columbus Bloomington Hospital
Region	11.	Baptist Hospital—Louisville
Region	12.	Deaconess Hospital—Evansville
Region	13.	St. Anthony Hospital—Terre Haute

We secured the endorsement of the Board of Trustees for:

(1). The Hospital Emergency Administrative Radio System (Motorola Corp.).

(2). The 911 Emergency Telephone Number (Bell System).

(3). The "Sign of Life" for Indiana highways.

Members of our commission have begun the preliminary planning for local emergency radio nets. Members of our state staff skillfully guided a resolution in the legislature promoting 911. We have a working relationship with Indiana Bell executives which should lead to further action on 911. We have secured local, state and federal consent for a demonstration highway sign project in emergency service region number five.

We had planned to have a preliminary feasibility study of air evacuation methods, but have not yet achieved this. It is important to know the newest air ambulance equipment and operating techniques. However, technical and professional study should be concentrated on whether it is practical or possible to have such service. It is the consensus of our commission, and the experts whom we have consulted, that legislative efforts to upgrade ambulance operations are necessary. We believe that ISMA should lead this effort, rather than other professional or lay groups.

We suggest that ISMA should make a stronger effort in the field of accident prevention. There is a need for leadership in the effort to reduce drunk driving and to exclude the habitual traffic offender, the psychopath, and the physically disqualified from gaining the driving privilege. There is, even now, too little effect from the campaign for the use of seat and shoulder belts and other safety devices. Who understands these problems better than the doctors who provide care for the accident victims? Certainly our profession can provide the skill and energy to translate plans and programs into effective community action.

Our final commission meeting will take place in September. It will be devoted to preliminary planning for a statewide ambulance ordinance to be presented to the Board of Trustees and the Commission on Legislation prior to the 1971 legislature.

JOHN S. FARQUHAR, JR., M.D.,
Chairman

RAYMOND W. NICHOLSON, M.D.,
Vice-Chairman

ROBERT M. BROWN, M.D.,
Secretary

WILLIAM F. KERRIGAN, M.D.

ROLLA D. BURGHARD, M.D.
R. JAMES BILLS, M.D.
JAMES D. FINFROCK, M.D.
CHARLES A. RAU, M.D.
MELVIN D. COOK, M.D.
LARRY W. SIMS, M.D.
JAMES W. KRESS, M.D.
WILLIAM W. DRUMMY, M.D.
FREDERIC L. SCHOEN, M.D.
FORREST J. BABB, M.D.
NEAL E. BAXTER, M.D.

Resolution No. 69-1

Introduced by: DAVIESS-MARTIN COUNTY MEDICAL SOCIETY

HOUSE ACTION: Not adopted.

WHEREAS, the proponents of sex education have influenced a few medical societies to sanction their program in grade schools, and,

WHEREAS, a careful study of those sex programs indicates that their principal purpose is to further deteriorate the morals of our youth,

NOW, THEREFORE, BE IT RESOLVED, by the Daviess-Martin County Medical Society in special session this 2nd day of June, 1969, that it expresses its opposition to the SIECUS type of sex education, and requests the Indiana State Medical Association to do likewise.

Resolution No. 69-2

Introduced by: COMMISSION ON AGING

HOUSE ACTION: Adopted.

WHEREAS, the Commission on Aging of the Indiana State Medical Association has considered conditions which presently exist in many of Indiana's nursing homes, and,

WHEREAS, members of the commission have been advised of actual instances of poor administration and substandard care in many nursing homes, which may be due to the necessity of the administration recommending and supervising rehabilitation procedures, and,

WHEREAS, it is evident that in the interest of good medical treatment of older patients, the physicians must be primarily involved,

NOW, THEREFORE, BE IT RESOLVED, that members of the Indiana State Medical Association in order to exert greater influence in upgrading facilities and patient care be urged to maintain an active and continuing doctor-patient relationship with patients confined to all medical care facilities in addition to the acute general hospital facilities in the state.

Resolution No. 69-3

Introduced by: COMMISSION ON AGING

HOUSE ACTION: Adopted.

WHEREAS, the Commission on Aging of the Indiana State Medical Association has been on record for several years as promoting the goal of independent living for the elderly, as long as they are capable of it, and,

WHEREAS, the limitation on earnings of those receiving Social Security benefits tends to discourage useful and profitable employment, and,

WHEREAS, this inhibits healthful and enjoyable activity and promotes a negative outlook,

NOW, THEREFORE, BE IT RESOLVED, that the ISMA petition the U.S. Senators and the Congressmen from the state of Indiana to initiate and/or to support the elimination of this impediment to independent living, and,

BE IT FURTHER RESOLVED, that such remedial action be made effective as soon as possible.

Resolution No. 69-4

Introduced by: COMMISSION ON PUBLIC HEALTH

HOUSE ACTION: Adopted as amended.

WHEREAS, the problems of sex and venereal disease education in the public school system as well as use and abuse of dangerous drugs, especially among school-aged youth during the past year, have been studied in depth by the Commission on Public Health, and,

WHEREAS, these studies have revealed an ever-increasing effort by some groups at the national level to impose ideologies, which, in essence, attempt to divorce morality from sexual relationships in their proposed courses, and,

WHEREAS, these studies have further revealed that there is a virtual deluge of pornographic literature being circulated through the mails to the youth of this state, and,

WHEREAS, the concern of the Commission on Public Health is further amplified by President Nixon's announcement in 1969 of the need for stemming the flow of these unwholesome and deteriorating influences, and,

WHEREAS, at present there is an excellent storehouse of films and literature on the subjects of sex, venereal disease, and dangerous drugs available to the public school system in Indiana from the Indiana State Board of Health and the American Medical Association,

NOW, THEREFORE, BE IT RESOLVED, that this House of Delegates support the proposition that education in our schools on the subject of sex, venereal disease, and dangerous drugs is a local affair and should be voluntary. It should be locally guided, encouraged, and controlled by the parents, clergy, physicians, teachers, and interested citizens of the concerned community, and,

BE IT FURTHER RESOLVED, that this House of Delegates encourage its members to make themselves available to support and participate in any local training or instructional programs to assist teachers or school health personnel on the subjects of sex, venereal disease, and dangerous drugs, and,

BE IT FURTHER RESOLVED, that local educational units be encouraged to make use of the materials on the aforementioned subjects that are available from the Indiana State Board of Health, the Indiana State Medical Association and the AMA, and,

BE IT FURTHER RESOLVED, that the Indiana State Medical Association formulate a position statement which permits retention of traditional moral concepts in school instruction in subjects of sex, venereal disease, and dangerous drugs; this to be done in cooperation with the Indiana State Board of Health and the Department of Public Instruction in Indiana to aid in carrying out the full intent of this Resolution.

Resolution No. 69-5

Introduced by: FUTURE PLANNING COMMITTEE

HOUSE ACTION: Adopted.

RESOLVED, that the Committee on Future Planning recommends to the Indiana State Medical Association House of Delegates that appropriate action be taken to (a) make available to specialty organizations (this includes Academy of General Practice) in Indiana the secretarial and mailing facilities of ISMA and (b) encourage specialty sessions in conjunction with and coordinated with ISMA meetings. Each specialty group would then be responsible for their scientific session. ISMA might then elect to sponsor no scientific sessions of its own.

esolution No. 69-6

ıtroduced by: FUTURE PLANNING COMMITTEE

HOUSE ACTION: Adopted.

RESOLVED, that the Committee on uture Planning recommends to the Inana State Medical Association House of elegates that they sponsor a committee ith appropriate representatives from all I.D. organizations in Indiana with the ission of:

(a) Exploring the feasibility of all organizations merging into a single federation under ISMA.

(b) Formulate a plan for accomplishing this and giving all groups an equitable representation in the ISMA House of Delegates and trustees.

(c) Explore the feasibility of defining units, other than only counties, as equivalent units within ISMA. (For example, a large hospital staff, a geographic region with common interests, a large specialty group, etc.)

esolution No. 69-7

ntroduced by: FUTURE PLANNING COMMITTEE

HOUSE ACTION: Not adopted.

RESOLVED, that the Committee on uture Planning recommends to the Indiana State Medical Association House of)elegates that the Constitution be mended to include the following ways of etting new, wider and more active particiation of the membership:

(a) ISMA trustees and AMA delegates and members of the ISMA House of Delegates be elected by a vote of the entire membership which they represent.

(b) All elections should be by mail ballot.

(c) At least two candidates, for every trustee and delegate office, be submitted by the nominating committee.

(d) To win a candidate must have 35% plurality of the entire membership —not just a majority of the votes cast. If the candidate receives less than the 35%, the election would be invalid and a new election would be held.

(e) A trustee and a delegate can be re-elected for a maximum of three terms in succession. He must then remain a non-candidate for the same office for one term before seeking that office again.

esolution No. 69-8

ntroduced by: FUTURE PLANNING COMMITTEE

HOUSE ACTION: Not adopted.

RESOLVED, that the Committee on Future Planning recommends to the Indiana State Medical Association House of Delegates that legislation be prepared for presentation to the Indiana State Assembly by interested members of that assembly to combat on a legal basis the ever-increasing problems of medical liability.

One specific recommendation is that legislation be prepared for use of medico-legal panels for pre-trial investigation. Another should be designed to correct the abuses associated with the contingency fee concept.

Resolution No. 69-9

Introduced by: DAVIESS-MARTIN COUNTY MEDICAL SOCIETY

HOUSE ACTION: Not adopted.

WHEREAS, many physicians have been influenced by propaganda to repeat the socialist cliche that medical care is a right, and,

WHEREAS, there could be no medical care unless individuals expended the time, money and personal energy necessary to acquire the knowledge to practice medicine for the needs of the ill and for their own sustainance, and,

WHEREAS, the ability to practice medicine is the property of an individual, it cannot rightfully be taken from him and given to another person without his consent except by violation of the basic rights of ownership,

NOW, THEREFORE, BE IT RESOLVED, that the Daviess-Martin County Medical Society in regular session this 21st day of July, 1969, goes on record as opposing the fallacy of medical care as a right and requests such a resolution be adopted by the ISMA at its October 1969 session, and,

BE IT FURTHER RESOLVED, that we consider medical care to be a service that can be purchased by those who seek it, or can be freely given by the physician, to those who cannot pay for it.

Resolution No. 69-10

Introduced by: FORT WAYNE (ALLEN COUNTY) MEDICAL SOCIETY

HOUSE ACTION: Adopted as amended.

WHEREAS, the ethics of the great majority of persons who hold licenses in the healing arts prohibit advertising, and,

WHEREAS, the few who do advertise their healing arts are frequently perpetrating fraud upon the public, and,

WHEREAS, several state legislatures, including Illinois and Kentucky, have seen fit to make healing art advertising illegal,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association urge our state legislature to prevent advertising of implied claims in the healing arts.

Resolution No. 69-11

Introduced by: MARION COUNTY MEDICAL SOCIETY

HOUSE ACTION: Referred to the Commission on Public Health.

WHEREAS, the 1969 Indiana General Assembly amended the Acts of 1949, c. 157, s. 810, as amended by the Acts of 1959, c. 34, s. 1, to make it unlawful for school authorities "to employ administrative personnel, clerical personnel, teachers, janitors, maintenance personnel, bus drivers or food handlers who are addicted to drugs, or who are intemperate, or who have tuberculosis or syphilis in an infectious stage," and,

WHEREAS, the statute requires an *annual physical examination* "for tuberculosis, including adequate laboratory tests and diagnostic x-rays" prior to employment of such personnel on a permanent or temporary basis, and,

WHEREAS, requirement of an *annual physical examination*, if the phrase were interpreted literally, would be impractical and prohibitively costly for school administrations,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association be urged to seek amendment of the 1969 amendment to provide only that a Mantoux intradermal skin test for tuberculosis be required, and then only for school personnel having contact with pupils; that reactors be referred to private physicians for further examination and testing, and that the school authorities concerned be advised of the results of the testing.

Resolution No. 69-12

Introduced by: MARION COUNTY MEDICAL SOCIETY

HOUSE ACTION: Adopted and referred to the Board of Trustees.

WHEREAS, medical diagnosis is an integral part of the practice of medicine and diagnostic services are physicians' services, and,

WHEREAS, the provision of so called "pre-admission testing" by Blue Cross Plans involves provision of diagnostic medical services to ambulatory patients, and,

WHEREAS, provision of pre-admission testing under hospital care insurance

limits the site of service to the hospital and payment for this service to the hospital, and,

WHEREAS, these restrictions inhibit attending physicians in selecting where and to whom to refer patients for these medical services, and,

WHEREAS, these restrictions discriminate against the independent practice of radiology by physicians in offices and in hospitals, and,

WHEREAS, the insurance of medical benefits is the purpose of Blue Shield Plans and commercial medical care insurers, and,

WHEREAS, provision of insured ambulatory diagnostic benefits eliminates some medically unnecessary occupancy of hospital beds, and,

WHEREAS, ambulatory diagnostic benefits are desired by patients, have been recommended by spokesmen for government, labor and management, and will be made available through pre-payment,

NOW, THEREFORE, BE IT RESOLVED, that the House of Delegates of the Indiana State Medical Association requests and urges Blue Shield Plans and other insurers of physicians' services in Indiana to aggressively extend provision of ambulatory benefits to those insured, and,

BE IT FURTHER RESOLVED, that the Indiana State Medical Association notes that provision of ambulatory diagnostic benefits by Blue Cross and insurers of hospitalization restricts patients and physicians in freely selecting where these medical services will be accomplished and by whom.

Resolution No. 69-13

Introduced by: MARION COUNTY MEDICAL SOCIETY

HOUSE ACTION: Adopted and referred to the Board of Trustees.

WHEREAS, there continues to be a shortage of physicians in Indiana, especially in rural areas and in urban areas of low economic classification, and,

WHEREAS, provision of such medical services and the retention of physicians are a joint responsibility of the medical profession and the community in Indiana, and,

WHEREAS, individuals and organizations throughout the state, outside the medical profession, cognizant of these needs, are increasingly appealing to organized medicine for assistance in these areas of concern, and,

WHEREAS, the urgency of developing constructive programs to meet these appeals for the delivery of health services is now paramount,

NOW, THEREFORE, BE IT RESOLVED, that the House of Delegates of the Indiana State Medical Association refer the problem of the establishment of such services, as well as the retention of physicians in Indiana, to the Board of Trustees, and,

BE IT FURTHER RESOLVED, that the Board of Trustees be prepared to report back to the October, 1970, House of Delegates with a statement of their accomplishments and possible solutions.

Resolution No. 69-14

Introduced by: MARION COUNTY MEDICAL SOCIETY

HOUSE ACTION: Adopted and referred to the Board of Trustees.

WHEREAS, the Indiana Plan for Medical Education has shown progressive growth since its inception, and,

WHEREAS, incorporated into the plan, have been new concepts to keep pace with the increasing pressures of the public and government for the delivery of health services to all with the highest degree of economy and maintenance of quality, and,

WHEREAS, the aims of the Indiana Plan, as originally established, are being accomplished, with a steady progression of new imaginative programs, and,

WHEREAS, these aims have been delineated as follows:

1. To Provide Effective Medical Education for a Large Student Body;
2. To Provide a Wider Variety of Educational Opportunities;
3. To Increase the Number and Quality of Internship and Residency Programs in Indiana;
4. To Help Practicing Physicians in the State to Maintain a High Level of Professional Competence;
5. To Provide in Several Localities Experience in Formal Medical Education;
6. To Encourage Young Physicians to Practice in Indiana;

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association reaffirm its strong endorsement of the Plan, and request the Board of Trustees of the association to maintain constant liaison with the Indiana University School of Medicine with the objective of lending continuous support and assistance to the Plan's present and future needs, and,

BE IT FURTHER RESOLVED, that the Board of Trustees report to the House of Delegates at the October, 1970, Convention of its efforts in aiding in the implementation of the Plan.

Resolution No. 69-15

Introduced by: MARION COUNTY MEDICAL SOCIETY

HOUSE ACTION: Adopted a amended and referred to the Board o Trustees.

WHEREAS, events are continually takin place and decisions are being made i Washington which clearly indicate a pa tern which is going to produce change dramatic and fundamental in the deliver of health care, and,

WHEREAS, at a recent meeting a repre sentative of the Department of HEW ind cated the President told the nation's pres that he knew the country's health car system was in deep trouble but he ha not appreciated just how bad things reall are, and,

WHEREAS, Dr. Egeberg is credited wit having said "The condition is 'grave tending to 'critical'," and the remedie that are called for will have to be full appropriate to the condition they are mean to correct, and,

WHEREAS, the government is attackin the cost of health care as one means o reducing the cost of these programs, and

WHEREAS, we continually hear rumor and comments that the method of deliver of health care so as to provide the qualit and quantity of treatment by the public i still not adequate,

NOW, THEREFORE, BE IT RE SOLVED, that the Board of Trustees b made to study all the whole question o delivery of health care which would in clude additional personnel; neighborhoo clinics; provision of services in under privileged areas; and the method of f nancing of such care.

Resolution No. 69-16

Introduced by: MARION COUNTY MEDICAL SOCIETY

HOUSE ACTION: Adopted and re ferred to the Board of Trustees.

WHEREAS, government planners an others have recognized the supply of healt personnel is not adequate to meet th demand, and,

WHEREAS, at the recent meeting o the American Medical Association in Ne York City the American Medical Assoc ation concurs that the supply is not ade quate to the demand, and that there is maldistribution of health care personne and,

WHEREAS, it is evident that the gov ernment tends to place more and mor people to various medical programs fostere by the government, and,

WHEREAS, the question of health ma

wer is one which is facing every segment the practice of medicine,

NOW, THEREFORE, BE IT RE-)LVED, that the Board of Trustees be arged with the responsibility of:

(1) Studying the question of provision of adequate health manpower;

(2) To maximize whatever productivity potentials do exist;

(3) Establish long-range goals of recruitment, utilization and training of specific types of health manpower;

(4) Validation, through health team studies, and consultation with concerned medical specialty societies, of the need for new helping roles in various segments of the health care system;

(5) Determination of whether existing categories of health manpower—with or without additional training—can fill these supportive roles or whether new types of personnel must be trained;

(6) Clarification of the legal and professional status and obligations of such new or existing personnel, their career needs and their supervisory relationship to the physician;

(7) Coordination with the activities of other elements of the health system, so as to identify common recruitment and training needs including the feasibility of core curricula, the potential for lateral and vertical mobility through development of educational continua and experience equivalents, and the immediate trade-offs necessary in terms of the overall manpower shortage;

(8) The possibility of increasing the supply of health manpower by studying ways to more effectively retain in the health field the highly trained military medical corpsmen and technicians being discharged into civilian life;

(9) To determine methods for appropriate training and licensing and certification of such personnel, and,

BE IT FURTHER RESOLVED, that the)ard of Trustees of the ISMA report ıck to the House their findings, any commendations or plans for consideration this House at its 1970 meeting.

esolution No. 69-17

ıtroduced by: MARION COUNTY MEDICAL SOCIETY

HOUSE ACTION: Not adopted.

WHEREAS, the President's Commission)ted that "requirements of quality con-ols in formal education and licensure ıve been the primary means of assuring ıat physicians use the best techniques ıd information available. But with the creasing pace of medical advances these one time controls are not enough. The physician's education must be continued as long as he practices," and,

WHEREAS, the commission has recommended that "professional societies and state governments should explore the possibility of periodic relicensing of physicians and other health professionals. . . .," and,

WHEREAS, the American Medical Association as well as some other state associations have this matter under consideration,

NOW, THEREFORE, BE IT RESOLVED, that the Board of Trustees study and report and be responsible for a plan that would do the following:

(a) Establish a one year pilot program to test the feasibility of establishing association-wide continuing medical education requirements and that the program be similar to that of the American Academy of General Practice;

(b) That under this program the continuing medical education requirements be set at 50 hours or units each year;

(c) That each specialty group be given the responsibility of recommending the forms and programs of continuing medical education to be accredited for the field of practice and the unitage value;

(d) That meeting the continuing medical education requirements for the Academy of General Practice be considered equivalent to fulfilling the continuing medical education requirements;

(e) That special consideration be given to members who are not in common fields of practice, and that accredited courses outside a member's field of practice be allowed to apply to his general requirements;

(f) That the Board form a special advisory committee consisting of one member from the Indiana Academy of General Practice and one from each of the major specialty groups;

(g) That this committee give full consideration to every problem in which arbitration of any kind is needed;

(h) That this new committee have as its major function the administration of this program of continuing medical education requirements;

(i) That a study be made to require a proof of having participated for a given number of hours in continuing medical education as a prerequisite for a renewal of a license to practice medicine in this state.

Resolution No. 69-18

Introduced by: MARION COUNTY MEDICAL SOCIETY

HOUSE ACTION: Adopted as amended and referred to the Board of Trustees.

WHEREAS, the Indiana State Medical Association and its component county medical societies have the responsibility to demonstrate to the citizens of Indiana that Indiana physicians possess the most modern medical knowledge, and,

WHEREAS, the Indiana State Medical Association and its component county medical societies have a primary responsibility to the citizens of Indiana to assure that the medical care rendered to them is of the highest quality, and,

WHEREAS, the American Medical Association has recognized that continuing medical education is a necessity in the modern day practice of medicine,

NOW, THEREFORE, BE IT RESOLVED, that this House of Delegates instruct the Board of Trustees to study this whole matter of methods of providing continuing certified education including self-assessment programs, and,

BE IT FURTHER RESOLVED, that the Board present to this House its findings and a recommended plan for this House to consider at its annual meeting in 1970.

Resolution No. 69-19

Introduced by: MARION COUNTY MEDICAL SOCIETY

HOUSE ACTION: Adopted as amended and referred to the Board of Trustees.

WHEREAS, the American Medical Association has established a special Committee of Peer Review, and,

WHEREAS, medicine has been challenged to provide its own mechanisms for assuring the confidence and quality of medical care,

NOW, THEREFORE, BE IT RESOLVED, that this House of Delegates instruct the Board of Trustees to bring this resolution to the attention of the proper committee to fully study the AMA Peer Review Report, and,

That this committee bring to the 1970 meeting of the House of Delegates a plan for implementation of the Peer Review Committee.

Resolution No. 69-20

Introduced by: GRANT COUNTY MEDICAL SOCIETY

HOUSE ACTION: Adopted and referred to the Board of Trustees.

WHEREAS, all colleges and universities require each new student to have physical examinations by physicians, and,

WHEREAS, each of these schools of ad-

vanced learning has a different form for this examination, and,

WHEREAS, at least one of these forms is quite difficult to read,

NOW, THEREFORE, BE IT RESOLVED, that the 1969 House of Delegates of the Indiana State Medical Association instruct the Board of Trustees to appoint a proper committee to meet with the Student Health Departments of at least all the state schools and possibly all those units of higher learning within the state to bring about a common form.

Resolution No. 69-21

Introduced by: BOARD OF TRUSTEES

HOUSE ACTION: Adopted.

WHEREAS, college health physicians have indicated an interest in becoming more active within the Indiana State Medical Association, and,

WHEREAS, the creation of a Section on College Health Physicians would be a means of fostering closer relationship, and,

WHEREAS, the Board of Trustees concurs that this is an important segment in the delivery of health care to the younger people of our state,

NOW, THEREFORE, BE IT RESOLVED, that Chapter III, Section 1, of the Bylaws be amended by adding thereto the following: "n. College Health Physicians," renumbering the present line "n" to line "o."

Resolution No. 69-22

Introduced by: BOARD OF TRUSTEES

HOUSE ACTION: Adopted and referred to the Commission on Constitution and Bylaws.

WHEREAS, there is a need for the members of the Indiana State Medical Association to become more familiar with the activities of the Student American Medical Association at Indiana University School of Medicine, and,

WHEREAS, members of SAMA have shown great interest in the affairs of Indiana State Medical Association and American Medical Association by attendance and participation at meetings of various committees and commissions, at the Board of Trustees' meetings, and at the ISMA and AMA conventions, and,

WHEREAS, the elected officers of SAMA at I.U. Medical School have indicated a desire on the part of their members to become more active in Indiana State Medical Association, and,

WHEREAS, the AMA has granted the national SAMA representation in the AMA House of Delegates,

NOW, THEREFORE, BE IT RESOLVED, that the House of Delegates of Indiana State Medical Association grant the Indiana University Chapter of SAMA representation in its House of Delegates.

Resolution No. 69-23

Introduced by: BOARD OF TRUSTEES

HOUSE ACTION: Adopted.

WHEREAS, inflation has seriously diluted the purchasing power of our dues dollar, and,

WHEREAS, expansion of our staff and activities has increased the budget to the point where present income from dues will barely meet our expenses, and,

WHEREAS, valuable employees must be given adequate salary increases if their services are to be retained, and,

WHEREAS, there are desirable new programs contemplated by the officers and Board of Trustees which will require additional income for implementation,

NOW, THEREFORE, BE IT RESOLVED, that the House of Delegates of ISMA increase the annual dues in the amount of $10.00 effective 1 January, 1970.

Resolution No. 69-24

Introduced by: BOARD OF TRUSTEES

HOUSE ACTION: Adopted as amended.

WHEREAS, inflation has seriously diluted the purchasing power of the dollar, and,

WHEREAS, our last state dues increase was in 1964, and,

WHEREAS, our Board of Trustees and staff has repeatedly effected substantial economy in our operations,

NOW, THEREFORE, BE IT RESOLVED, that the Board of Trustees report each year to the House of Delegates a recommendation as being an appropriate escalation in the dues structure based upon the cost of operations.

Resolution No. 69-25

Introduced by: WASHINGTON COUNTY MEDICAL SOCIETY

HOUSE ACTION: Not adopted but referred to the Commission on Legislation which, with the legal advice of counsel of the ISMA, study the matter and report back to the next ISMA House of Delegates in 1970.

WHEREAS, the Indiana Statutes relative to the revocation and/or suspension of licenses to practice medicine were last reviewed in 1901, and,

WHEREAS, the language of existing statutes and the procedures therein provided are so antiquated in modern society as to be ineffective to fully protect the public against misconduct or malpractice within the medical profession, and,

WHEREAS, there is no procedure provided or authority given whereby upon complaint of a duly constituted medical society, a temporary suspension of license can be obtained, and,

WHEREAS, upon complaint being made by a duly constituted medical society temporary suspension of license should be available and such society should have made available to it all investigative procedures and reports,

NOW, THEREFORE, BE IT RESOLVED:

1. That the Board of Medical Registration and Examination of the State of Indiana, the Indiana State Medical Association and all other appropriate agencies be urged to bring these matters to the attention of the 1971 session of the General Assembly.

2. That the General Assembly be urged to undertake and adopt legislation addressed to these problems.

3. That particular attention be given to the problem that no procedure exists whereby a temporary suspension of license to practice can be issued during an investigation of misconduct or malpractice where such complaint is made by a duly constituted medical society.

4. That further attention be given to the fact that no authority exists for an individual or committee to take immediate action so as to fully protect the public.

5. That upon complaint being made by a duly constituted medical society, some authority be created whereby a license to practice can be temporarily suspended for a period of not to exceed 60 days thereby protecting the public from misconduct or malpractice.

6. That investigations of complaints include compulsory psychiatric evaluation of the person complained of and that such evaluation be made available to the complaining medical society.

7. That the primary concern in this field be directed toward the protection of the public from misconduct or malpractice by licensed physicians and surgeons.

Resolution No. 69-26

Introduced by: MARION COUNTY MEDICAL SOCIETY

HOUSE ACTION; Not adopted.

WHEREAS, the so-called Resolution 26, or the going rate concept, has predisposed to a great deal of troublesome and unwanted correspondence between Blue Shield and the physicians of Marion County, and,

WHEREAS, the same resolution has caused a deterioration in doctor-patient relationships, and,

WHEREAS, the same resolution has put Blue Shield in the position of, directly or

lirectly, setting doctors' fees,

NOW, THEREFORE, BE IT RE-)LVED, that the Marion County Medical ciety, in special session this 19th day August, 1969, goes on record as opposing :solution 26 and respectfully requests the diana State Medical Association, at its :tober, 1969, session to adopt a resolution withdraw from the agreement, known as :solution 26, effective December 31, 1969.

:solution No. 69-27

ıtroduced by: BOARD OF DIRECTORS, MARION COUNTY MEDICAL SOCIETY

HOUSE ACTION: Adopted as ıended and referred to the Board Trustees.

WHEREAS, there is misunderstanding d confusion regarding Blue Cross and ue Shield Insurance Certificates, and,

WHEREAS, many of these policies are adequate to protect Blue Cross-Blue ıield certificate holders, and,

WHEREAS, no physician is present, or rticipates officially, in discussion of cer-icates presented to major corporations r medical coverage, and,

WHEREAS, there is marked discrimi-tion of compensation among medical, rgical care and hospital benefits,

NOW, THEREFORE, BE IT RE-)LVED, that the Board of Trustees of e Indiana State Medical Association re-ew the certificates of Blue Cross and Blue ıield and offer recommendations to im-ove the coverage of Blue Cross and Blue ıield certificates, and,

BE IT FURTHER RESOLVED, that the)ard of Trustees of the Indiana State edical Association report its findings to e House of Delegates of the Indiana State edical Association at its next annual eeting in 1970.

esolution No. 69-28

ıtroduced by: JACKSON-JENNINGS COUNTY MEDICAL SOCIETY

HOUSE ACTION: Adopted and re-rred to the Board of Trustees.

WHEREAS, the deliberation, discussion, ıd final actions taken by the Board of rustees are of extreme importance,

NOW, THEREFORE, BE IT RE-)LVED, that within two weeks after each)ard meeting the Executive Secretary will mpile a brief resume of the actions of e Board including any money allocated any project and such report will be ailed to each county president, each state elegate and alternate delegate, each AMA delegate and alternate delegate. This report should be mailed in a distinctive envelope, i.e., red-bordered letter. We realize that reports of Board meetings are published in *The Journal* but few physicians take time to seek out such reports to read.

Resolution No. 69-29

Introduced by: JACKSON-JENNINGS COUNTY MEDICAL SOCIETY

HOUSE ACTION: Adopted and referred to the Board of Trustees.

WHEREAS, Chapter VII, Section 2 of the Indiana State Medical Association Bylaws reads in part as follows, "Each trustee shall be organizer, peacemaker, and censor for his district. He shall visit the counties in his district at least once a year for the purpose of organizing component societies where none exist; for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district, the same to be published in the number of *The Journal* which is issued immediately preceding the Annual Convention," and,

WHEREAS, the future of the private practice of medicine in America is in grave danger, therefore communication from the Board of Trustees to the members of ISMA is of extreme importance, and,

WHEREAS, physicians who assume the office of a trustee of ISMA should also with integrity assume the responsibilities of this office,

NOW, THEREFORE, BE IT RESOLVED, the trustee of each district shall assume the duties as stated in the aforementioned Section 2 of the Bylaws and that such visits to the county societies in his district be recorded monthly in the state *Journal* as they occur.

Resolution No. 69-30

Introduced by: JACKSON-JENNINGS COUNTY MEDICAL SOCIETY

HOUSE ACTION: Not adopted.

WHEREAS, in the past the trustees of 90% of the districts have been elected by less than 20% of the members of the district who attend the district meeting, and,

WHEREAS, the duties and responsibilities of the members of the Board of Trustees each year increase in scope and magnitude,

NOW, THEREFORE, BE IT RESOLVED, in the future the trustee will be elected by ballots mailed to each member of his district. Nominations for the office of trustee shall be sent to the office of the executive secretary of the ISMA at least three weeks prior to the district meeting —the secretary will then mail ballots to the physicians of that district requesting their return within two weeks so that the results of the election can be announced at the district meeting. Alternate trustees shall be elected in the same manner. If only one candidate is nominated he will be declared elected and the members of the district will be so notified.

Resolution No. 69-31

Introduced by: JACKSON-JENNINGS COUNTY MEDICAL SOCIETY

HOUSE ACTION: Not adopted.

WHEREAS, each year there are resolutions presented to the AMA House of Delegates concerning increasing their public relations, and,

WHEREAS, each year nothing is done, and,

WHEREAS, each year there is an increasing amount of criticism aimed at physicians and the AMA by all the communications media including T.V. commentators, government officials, and even panel shows such as "The Tonight Show,"

NOW, THEREFORE, BE IT RESOLVED, that the AMA House of Delegates at its next meeting in November appoint an Ad Hoc Committee to study in detail this question with the idea of beefing up its public relations activities. Possibly setting up a permanent public relations group with such a man as Dr. Edward Annis as its chairman. The story of medicine *must* be told to the public.

Resolution No. 69-32

Introduced by: ST. JOSEPH COUNTY MEDICAL SOCIETY

HOUSE ACTION: Adopted.

WHEREAS, malpractice suits against doctors of medicine are increasing in number in Indiana, and,

WHEREAS, these and future law suits against doctors may endanger the best practice of medicine, and,

WHEREAS, other state medical societies have made efforts to try to stem the number of malpractice suits against doctors,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association, through its proper commission or committee and legal counsel, make a study of the situation and if findings

justify it, then the Indiana State Medical Association should institute legislation to be presented at the next General Assembly of the State Legislature to try to curb the number of malpractice suits, and also a study be done of the advisability of setting up workshops on methods to prevent incidents that lead to malpractice suits.

Resolution No. 69-33

Introduced by: ST. JOSEPH COUNTY MEDICAL SOCIETY

HOUSE ACTION: Adopted as amended and referred to the Commission on Constitution and Bylaws.

WHEREAS, many Doctors of Medicine recognize that there are many Doctors of Osteopathy who are well trained and practice a strictly scientific type of medicine, and,

WHEREAS, there are many Doctors of Osteopathy who desire to further increase their abilities to practice a good scientific medicine, and,

WHEREAS, the American Medical Association has proposed that qualified Doctors of Osteopathy be permitted to attend staff and county society meetings, and,

NOW, THEREFORE, BE IT RESOLVED, that Chapter 1, Section 2, of the Bylaws of the Indiana State Medical Association be amended to read as follows:

Section 2—the term "member" as used in these Bylaws, unless otherwise indicated, shall mean both active and senior members of component county medical societies who hold either the degree of Doctor of Medicine, Bachelor of Medicine, or who hold an unrestricted license to practice medicine and surgery the decision of this matter is still left in the hands of the local society to determine the qualifications of its members.

Resolution No. 69-34

Introduced by: LA PORTE COUNTY MEDICAL SOCIETY, INC.

HOUSE ACTION: Adopted.

WHEREAS, certain members of the LaPorte County Medical Society, Inc., who are directly involved with the medical care of the inmates of Indiana State Prison, Michigan City, Indiana, have been critical of working conditions in the prison hospital, and,

WHEREAS, the members of the LaPorte County Medical Society, Inc., feel that the major factor interfering with good medical care in the Indiana State Prison, Michigan City, Indiana, is the lack of a coordinated medical care program within the Department of Correction, which program could organize the medical care for the Correction Department with special reference to procurement of personnel, equipment and supplies; and especially could effect long range planning, and savings through more efficient utilization of funds and services for all the prisons and corrections institutions in the state,

NOW, THEREFORE, BE IT RESOLVED, that the LaPorte County Medical Society, Inc., urges the Indiana State Medical Association to recommend to the Governor of the State of Indiana and the State Legislation Council that a medical department be established within the Department of Correction, the purpose of which would be to organize and administer the medical care program for all the corrections institutions in the state.

Resolution No. 69-35

Introduced by: BOARD OF TRUSTEES

HOUSE ACTION: Adopted as amended.

WHEREAS, at the annual meeting of the Indiana State Medical Association in October, 1968, the House of Delegates referred Resolution 68-10 to the Board of Trustees and mandated the Board to act upon the matter and present a definite plan at next year's (1969) first meeting of the House of Delegates, (Reference *ISMA Journal*, January, 1969, page 130), and,

WHEREAS, the Board of Trustees has acted upon this matter as recorded in the supplemental report of the chairman of the Board,

NOW, THEREFORE, BE IT RESOLVED, that the membership of the Board of Trustees of Indiana State Medical Association be determined as follows:

1. There shall be no alteration of the present geographic boundaries of the Trustee Districts.

2. Each District shall have at least one Trustee and one Alternate Trustee.

3. Each District shall have one Trustee and one Alternate Trustee for each 600 active members or major fraction thereof, (i.e., when a District has 901 active members, it shall have two Trustees and two Alternate Trustees, etc.), and that this change be immediately effective.

Resolution No. 69-36

Introduced by: LAKE COUNTY MEDICAL SOCIETY

HOUSE ACTION: Adopted as amended.

WHEREAS, physicians in the state of Indiana have historically provided the services to the indigent under the Department of Public Welfare and Township Trustee Medical Programs at reduced fees and,

WHEREAS, during the past year, physicians have experienced increasing delay in payment for these services, even at these reduced rates, for at least six months, and in some cases as much as one and two years, and,

WHEREAS, despite assurances that this condition would be corrected, such has not been the case, and,

WHEREAS, certain physicians' practices consist of as much as 50% in the care of such patients, and,

WHEREAS, the advent of statewide billing and Medicaid Program January 1st 1970, portends even more difficulty in this respect, and,

WHEREAS, tax funds for the payment of these services have been raised and are now in possession of such governmental agencies as county governments,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association request an investigation by the Indiana State Department of Public Welfare into the medical care program in Indiana with a view to expediting payment to such physicians, and an assurance as to the conduct of the program beginning January 1st, 1970.

Resolution No. 69-37

Introduced by: OWEN-MONROE COUNTY MEDICAL SOCIETY

HOUSE ACTION: Adopted and referred to the Board of Trustees.

WHEREAS, teachers of elementary grades are expected to instruct boys and girls in health education as part of their normal classroom studies, and,

WHEREAS, the course content of this subject area is broad and is being extended into previously untouched areas, and,

WHEREAS, there is great, and increasing, public interest in the areas of health education, especially that concerned with so-called "sex education", and,

WHEREAS, teachers are currently certified with only one semester of instruction in health education,

NOW, THEREFORE, BE IT RESOLVED, that the Board of Trustees of ISMA shall endeavor, with appropriate educators' associations, to change the requirements for certification so that teacher will receive proper preparation for instructing in health education.

Resolutions of Appreciation

esolution to Temple, olumbia Club, and thenaeum

WHEREAS, the success of any meeting contingent upon the cooperation of the lministration of the physical facilities ilized, and,

WHEREAS, the 120th annual conven- on of the Indiana State Medical Associa- on has been, indeed, a success, a large art of which must be attributed to the forts of the managements of the Murat emple, the Columbia Club and the thenaeum, all of which has been out- anding,

NOW, THEREFORE, BE IT RE- OLVED, that this House of Delegates ex- ress to these organizations their heart- lt thanks for such assistance and direct e executive secretary of the association so inform them.

residential Resolution

WHEREAS, the presidency of the Indi- a State Medical Association is a demand- g official position which calls for long ours of time away from family and prac- ce, and,

WHEREAS, each succeeding presidency the association requires more contribu- ons of time as programs, plans and needs the organization grow, and,

WHEREAS, Dr. Patrick J.V. Corcoran has given unstintingly of his energies and enthusiasm, unselfishly, in this growth and development and has initiated programs of benefit to the association,

NOW, THEREFORE, BE IT RESOLVED, that this House of Delegates express its deepest appreciation to him for a long and arduous year of activity and accomplishment, and his unflagging personal attention to the affairs of the association on behalf of his fellow Hoosier physicians.

Resolution to Dr. Ralph V. Everly

WHEREAS, Dr. Ralph V. Everly, over many years, has been unstinting in his devotion to this association and to his medical society, and,

WHEREAS, his many achievements as president of the Marion County Medical Society, as chairman of the Building Committee of the Indiana State Medical Association and as chairman of the association's Executive Committee have been singular, and,

WHEREAS, Dr. Everly now has resigned as chairman of the Executive Committee,

NOW, THEREFORE, BE IT RESOLVED, that this House of Delegates convey to Dr. Everly its sincere appreciation for his most faithful service and our expression of the affection and gratitude it holds for him.

Resolution to Dr. Otis R. Bowen

WHEREAS, Dr. Otis R. Bowen, as speaker of the Indiana State House of Representatives, and,

WHEREAS, having served in this position of great responsibility with integrity and distinction, and,

WHEREAS, he has also served our members well as trustee of the 13th District of the ISMA, and,

WHEREAS, the members of ISMA, as well as the citizens of Indiana, do owe him a debt of gratitude,

NOW, THEREFORE, BE IT RESOLVED, that the Honorable Dr. Otis R. Bowen is hereby commended for exceptional public service and is accorded our thanks, appreciation and continuing support.

Place of Future Annual Conventions

Dates and places previously set:
1970—South Bend
1971—Indianapolis
1972—French Lick
1973—Indianapolis
1974—Upon motion duly made and seconded, the invitation to hold the 1974 annual convention in Evansville was accepted.

Adjournment

The House of Delegates adjourned, *sine die*, at 2 p.m. Thursday October 17, 1969.◄

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December 1969 Volume 62 No. 1

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Camarillo State Hospital 1440
Campbell Soup Company 1435
Dallas Southern Clinical Society 1434
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Hanger, J. E., Inc. 1430
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Highland Hospital 1445
Hook's Drugs 1400
Hynson, Westcott & Dunning, Inc. 1373
Indiana Medical Bureau 1446
Inland Steel Company 1385
Lederle Laboratories 1375, 1385, 1424-25
Lilly, Eli & Company 1392
Medical Protective Co. of Ft. Wayne 143
Mutual Medical Insurance, Inc. ....3rd Cove
Parke, Davis & Company 1423, 143
Pfizer Laboratories 1414-1
Poythress, Wm. P. & Co., Inc. 145
Quality Leasing, Inc. 143
Robins, A. H. Company, Inc. 1401-03, 143
Roche Laboratories ....1381-83, 1412-13, 4th Cove
Sandoz Pharmaceuticals 142
Searle, G. D. & Co. 1436-3
Silver Lake Lions Club 144
Smith Kline & French Laboratories 138
Strasenburgh Laboratories 144
Stuart Company, The ....2nd Cove
Suemma Coleman Home, The 144
WFBM-TV 143
Wabash Valley Hospital 145
Wyeth Laboratories 1396-97, 1448-4

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The JOURNAL

of the

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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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INDEX TO VOLUME 62

January through December, 1969

January	Pages	1 to 138	July	Pages	769 to 862
February	Pages	139 to 230	August	Pages	863 to 990
March	Pages	231 to 332	September	Pages	991 to 1182
April	Pages	333 to 432	October	Pages	1183 to 1274
May	Pages	433 to 520	November	Pages	1275 to 1372
June	Pages	521 to 768	December	Pages	1373 to 1550

SCIENTIFIC ARTICLES

An Emergency Air-Ground System for the Newborn with Respiratory Distress Syndrome (Arp-Dillon-Long-Boatwright) 547

Angina Pectoris, Carotid Nerve Stimulation in the Treatment of, (Elliott-King-Ross-McHenry) 176

A Survey of Continuing Medical Education in Indiana (Hickman-Stonehill-Brown-Lukemeyer) 29

Carotid Sinus Nerve Stimulation in the Treatment of Angina Pectoris (Elliott-King-Ross-McHenry) 176

Cataracts, The Cryoextraction of, A Comparative Study with Conventional Instruments (Alvis-Clark-Rich) 801

Cerebral Vascular Disease, Principles of Therapy in, (Dyken) 898

Circumcision, Infant, Subglanular Urethral Fistula from, (Lackey-Mannion-Kerr) 1305

Continuing Medical Education in Indiana, A Survey of, (Hickman-Stonehill-Brown-Lukemeyer) 29

Contraception, Court-Ordered, (Young - Young - Alverson - Young) 264

Coronary Care Unit, The, in a Small Hospital (Robinson) .. 895

Court-Ordered Contraception (Young-Young-Alverson-Young) 264

Current Legislation Proposals for the Multiple Handicapped Individual and the Indiana Physician (Roeske-Helveston) . 35

Digitalis, The Inotropic Effects of: A Review (Edmands-Greenspan) 268

Digitalis Toxicity: A Review (Stone-Fisch) 459

Dysbarism, The Dangers of, (Stonehill-Murray) 41

Esophagitis, Stenosing Non-Peptic, (Berman-Rowe-Waymire) 1404

Fistula Between Bowel and Urinary Tract (Nourse) 1207

Furosemide, Treatment of Congestive Heart Failure with, (Nay) 887

Gastric Distension During Tracheoesophageal Fistula Repair (Dryden) 46

Goodpasture's Syndrome in the Elderly, Report of a Case (Schmidt-Sternberg) 796

Graham Steell Murmur, The, Mimicked by the Murmur of Mitral Stenosis (Popp-Nasser-Feigenbaum-Tavel-Linback-Fisch) 165

Handicapped Individual, Multiple, Current Legislation Proposals for the, and the Indiana Physician (Roeske-Helveston) 35

Hypokalemia, Recognition and Management of, (Higgins) . 1299

Hypsarrhythmia Accompanying Tetany of the Newborn (Troy) 1216

Jejunum, Primary Malignant Tumor of the, (Maxam) 1398

Leiomyosarcoma of the Duodenum Treated by Pancreatoduodenectomy (Shah-Montgomery) 363

Malignancy, Advanced Gastrointestinal, Methotrexate Therapy of, (Ward-Mullins) 35

Methotrexate Therapy of Advanced Gastrointestinal Malignancy (Ward-Mullins) 35

Mycoplasma Pneumoniae in Families—A Therapeutic Study (Conway-Scully-West-Jensen-Senterfit-Drummy-Lenyo) 101

Negative Suction, The Postoperative Use of, in Urology (Mannion-Lloyd) 25

Obturator Obstruction of the Intestine: Report of Two Unusual Cases (Butz-Rench) 121

Pancreatoduodenectomy, Leiomyosarcoma of the Duodenum Treated by, (Shah-Montgomery) 36

Persistent Problems in Medical Care (Cohen) 131

Physician Manpower—"Telling It Like It Is" (Penrod) ... 90

Pneumoniae, Mycoplasma, in Families—A Therapeutic Study (Conway-Scully-West-Jensen-Senterfit-Drummy-Lenyo) ... 101

Primary Malignant Tumor of the Jejunum (Maxam) 139

Principles of Therapy in Cerebral Vascular Disease (Dyken) 89

Recognition and Management of Hypokalemia (Higgins) .. 129

Respiratory Distress Syndrome, An Emergency Air-Ground System for the Newborn with, (Arp-Dillon-Long-Boatwright) 54

Sedative Withdrawal Seizures (Kissel) 79

Stenosing Non-Peptic Esophagitis (Berman-Rowe-Waymire) 140

Subglanular Urethral Fistula from Infant Circumcision (Lackey-Mannion-Kerr) 130

Tetany of the Newborn, Hypsarrhythmia Accompanying, (Troy) 121

The Case of the Rocky Ripples (Lieberman) 80

The Coronary Care Unit in a Small Hospital (Robinson) .. 89

The Cryoextraction of Cataracts, A Comparative Study with Conventional Instruments (Alvis-Clark-Rich) 80

The Dangers of Dysbarism (Stonehill-Murray) 4

The Graham Steell Murmur Mimicked by the Murmur of Mitral Stenosis (Popp-Nasser-Feigenbaum-Tavel-Linback-Fisch) 16

The Inotropic Effects of Digitalis: A Review (Edmands-Greenspan 26

The Postoperative Use of Negative Suction in Urology (Mannion-Lloyd) 25

The "Rule of Bigeminy" (Mericle-Fisch) 17

The Shades of Green (Allen) 139

Tracheoesophageal Fistula Repair, Gastric Distension During, (Dryden) 4

Treatment of Congestive Heart Failure with Furosemide (Nay) 88

ELECTROCARDIOGRAM OF THE MONTH

ropine in A-V Block (Fisch) 367
ropine in Myocardial Infarction (Fisch) 1410
Dissociation: The Use of Isoproterenol (Isuprel®) (Fisch) 48
cemaker Electrocardiography (Fisch)
Pt. 1 910
Pt. 2 1028
Pt. 3 1229
Pt. 4 1316
Waves in Idiopathic Hypertrophic Subaortic Stenosis (Fisch) 808

FRACTURES AND ORTHOPEDIC PROBLEMS

nservative Management of Periarthritis of the Shoulder (Denham-Dingley) 376
e Development and Treatment of Deformity in Pseudoachondroplastic Dwarfs (Lindseth) 1220

PATH-FINDER

tibiotic Sensitivity Testing 1408
nal Function Tests 817

THE CANCER YOU VIEW

1 (Pittman-Siderys) 370

X-RAY CONFERENCE

eurysms and Arteriovenous Fistulae in a Hypernephroma (Lang) 276
teriographic Assessment of Viability of Bowel after Perforating Abdominal Injury (Lang) 1322
teriographic Diagnosis of a Bleeding Gastric Ulcer (Lang) 50
teriographic Diagnosis of Acute Pancreatitis (Lang) 1218
teriographic Presentation of a Rhabdomyosarcoma of the Thigh (Lang) 469
rebellar Hemangioblastoma (Lang) 1026
ju stration of the Lung (Lang) 913
aumatic Arteriovenous Fistulae of the Kidney (Lang-Fontenot-Johnson-Turner-St. Martin) 810

EDITORIALS

ortion and the Law in Indiana 52
MA Clinical Convention (Guest) 1238
logical Research 914
siness Action Needed to Push Ideas and Issues (Guest) . 380
ordination of Benefits in Group Health Insurance 471
abetes Detection Week 1237
Employment of the Handicapped 1033
Essential Facts in the Attack on Environmental Pollution (Guest) 53
Facts for the "Fickle Finger" 283
Final Report of the Drug Research Board 1033
Health Insurance, Coordination of Benefits in Group, ... 471
Indiana Medical Foundation 1326
Inflation is a Leaky Bucket (Guest) 1326
Medical Care Cost Escalator 1416
Men in Nursing 182
New Monthly Feature (Hill) 1417
Now's the Time to Utilize our Fresh Opportunities (Guest) . 914
Please Turn Down the Lights (Guest) 53
Progress in Auto Safety 283
Show Congress How Much Our States *Do* Care (Guest) 551
SKF Foundation Grows in Breadth and Volume 53
Son of Three-Legged Stool (Hickman) 1237
Struck By Lightning 550
The "AMA Annual" (Guest) 284
The Best Medical Care 380
The Laboratory Question (Guest) 1238
The Service Economy Grows—But Does It? (Guest) 472
The Ultimate Tranquilizer 819
Three-Legged Stool Revisited (Hickman) 1034
Uniform Anatomical Gift Law 819
What Malpractice Suits are Doing to You, the Patient (Guest) 1417
When I Was Three-and-Twenty (Guest) 550

SPECIAL FEATURES

AMA Auxiliary Announces Young People's Program 733
A Sign of Life on Indiana Highways (Farquhar) 480
Convention Art, Hobby Show Application Form 725
County Medical Society Officers Conference 933
County Medical Society—Scientific, Socio-Economic or Community Service—All These or Something Else? (Tupper) 483
Federally Approved Home Health Services Agencies in Indiana 553
Grandpa's Grandpa (Bornemeier) 1123
Index to House of Delegates Proceedings 93
Indiana Regional Medical Program (Leamnson) 1339
Interest in ISMA Preceptor Program Continues to Grow .. 922
Interprofessional Code of the Indiana State Medical Association and the Indiana State Bar Association 561

I.U. School of Medicine Postgraduate Courses 1209
Ivy Tech Health Occupation Courses 568
Lounge Talk (Hill) 1419
Lowell H. Steen, M.D., President, 1969-70 1334
Medicaid in Indiana (Sterrett) 920
Medicaid in Indiana (Sterrett) 1126
Medicare Approved Independent Clinical Laboratories 556
New HEW Regulation Limiting Medicaid Fees 1040
Preceptorship Proves Highly Rewarding (Bush) 62
Promoting Cooperative Effort in the Fight Against Heart Disease, Cancer, Stroke and Related Diseases 388
Report on Actions of the AMA House of Delegates, (22nd Clinical Convention, Dec. 1-4, 1968, Miami Beach, Fla.) .. 190
South American Medical Tour (Loh) 1427
The Katherine Hamilton Mental Health Center (Cavins) .. 1250
Third Annual Symposium of the National Pharmaceutical Council 60
Tyrannical Taxation (Blazey) 1252

REGULAR FEATURES

About Our Cover 29, 168, 360, 925, 1024, 1250
Abstracts, Book Reviews 76, 201, 305, 399, 495, 839, 960, 1144, 1260, 1349, 1430
Annual Meeting Dates of Professional Medical and Allied Organizations 65, 205, 297, 407, 499, 735, 857, 971, 1155, 1263, 1368, 1446
Blue Shield Series:
New Blue Shield Procedure and New Benefits 75
Your Blue Shield Professional Relations Staff 200
Moderating Costs 296
Blue Shield Operational Data: 1946-1968 408
Blue Shield Assists Physicians in Health Planning Activity 490
Your Blue Shield Board of Directors 545
Your Indiana Blue Shield Board of Directors 830
A Banner Year for Blue Shield 928
Blue Cross and Blue Shield "Best Buy" in Health Coverage 1130
What About Medical Care Cost? 1254
Indiana's Health Care Bill in 1968 $1,020,000,000 1336
The Blue Shield Claims Dollar: 1968 1422
Board of Health Report 86, 206, 319, 410, 516, 734, 835, 963, 1162, 1264, 1352, 1434
County, District News 90, 218, 328, 421, 514, 859, 1163, 1370, 1452
Day by Day with the FDA 189, 310, 921
Editorial Notes 55, 182, 284, 381, 474, 551, 820, 915, 1034, 1239, 1327, 1418
Fourth Estate 24, 162, 252, 349, 450, 535, 786, 1009, 1205, 1292, 1390
From The Journal 50 Years Ago 135, 19 278, 402, 509, 704, 842, 970, 1027, 1224, 1324, 14
Future Meetings, Seminars, Courses 87, 21 323, 419, 513, 858, 972, 1159, 1271, 13
Gleaned from the British Medical Journal (Hickman) 39 827, 1136, 12
Letters to the Editor 156, 246, 4
Medical Panorama:
The World Doth Turn (Cavins) .....
It Might Happen Here (Cavins) .....
Medicine at Law 67, 192, 290, 396, 486, 83 952, 1137, 1256, 1344, 14
Month in Washington 15, 150, 242, 344, 44 778, 876, 1013, 1200, 1288, 13
News from Indiana University School of Medicine 66, 29 485, 11
News Notes 83, 207, 311, 412, 504, 847, 96 1149, 1267, 1357, 14
President's Page (Corcoran) 11, 149, 24 343, 445, 531, 777, 875, 1005, 11
The Woman's Auxiliary Reports to ISMA
(Kephart) 56, 184, 286, 3
(Schneider) 479, 566, 823, 919, 1038, 1242, 1328, 14
Wanted: Physicians, Locations 70, 298, 408, 503, 829, 11
What's New? 23, 161, 251, 353, 455, 541, 79 873, 1003, 1195, 1285, 13

CONVENTION ISSUE

Announcement 10
Convention Arrangements Committees 10
Fifty-Year Club 10
House of Delegates 10
House of Delegates, Official Call to the, ... 10
Officers of ISMA, 1968-69 10
Officers of ISMA (pictures) 10
Program, 120th Annual Convention 10
Reference Committees 10
Reports of Commissions 10
Reports of Committees 10
Reports of Officers 10
Resolutions 11
Scientific Exhibits 11
Section Officers 10
Technical Exhibitors 11
Woman's Auxiliary Program 10

1969 CONVENTION

69—The Convention Story 1453

nvention Election Results: Dr. Malcolm O. Scamahorn Named President-Elect 1475

dex to House of Delegates Proceedings 1477

e Winners 1476

ASSOCIATION BUSINESS

ard of Trustees:

Nov. 17, 1968 222

Jan. 11, 1969 423

Mar. 26, 1969 975

June 28, 1969 1165

June 29, 1969 1165

ecutive Committee:

Nov. 16, 1968 91

Jan. 11, 1969 220

Feb. 12, 1969 428

Mar. 25, 1969 983

Apr. 26, 1969 984

May 25, 1969 986

June 28, 1969 987

YEARBOOK SECTION

pproved Hospitals in Indiana 705

pproved Mental Hospitals 709

ss A Narcotic Drugs 742

mmunity Centers for the Mentally Retarded 690

nstitution and Bylaws of the ISMA 750

aths of Indiana Physicians in 1968 746

sease Prevention by Immunization and Chemoprophylaxis . 736

liana Accredited Practical Nursing Schools 692

liana Accredited Schools of Professional Nursing 688

J. School of Medicine, Heads of Departments 703

ensed Nursing Homes in Indiana 710

embership Roster

Alphabetically 1/571

By Counties 34/604

Woman's Auxiliary 73/643

tpatient Mental Health Facilities in the State of Indiana: 1969 726

Poison Control Centers in Indiana and Adjacent States 730

Presidents of ISMA Since Its Organization 748

Professional Medical and Allied Organizations 698

Principles of Medical Ethics of the American Medical Association 765

State Elected Officials 678

State Health Organizations 680

Voluntary Organizations 702

AUTHORS

Allen, George S., M.D., (The Shades of Green) 1393

Alvis, David L., M.D., (The Cryoextraction of Cataracts, A Comparative Study with Conventional Instruments) 801

Arp, L. J., Ph.D., (An Emergency Air-Ground Transport System for the Newborn with Respiratory Distress Syndrome) 547

Berman, Jacob K., M.D., (Stenosing Non-Peptic Esophagitis) 1404

Blazey, A. G., M.D., (Tyrannical Taxation) 1252

Boatwright, C. L., M.D., (An Emergency Air-Ground Transport System for the Newborn with Respiratory Distress Syndrome) 547

Bornemeier, Walter C., M.D., (Grandpa's Grandpa) 1123

Brown, Charles R., M.S., (A Survey of Continuing Medical Education in Indiana) 29

Bush, K. W., (Preceptorship Proves Highly Rewarding) ... 62

Butz, Ralph O., M.D., (Obturator Obstruction of the Intestine: Report of Two Unusual Cases) 1213

Cavins, A. W., M.D., (It Might Happen Here) 828

Cavins, A. W., M.D., (The Katherine Hamilton Mental Health Center) 1250

Cavins, A. W., M.D., (The World Doth Turn) 64

Clark, George A., M.D., (The Cryoextraction of Cataracts, A Comparative Study with Conventional Instruments) .. 801

Cohen, Wilbur J. (Persistent Problems in Medical Care) .. 1310

Conway, T. J., M.D., (Mycoplasma Pneumoniae in Families—A Therapeutic Study) 1019

Denham, R. H., Jr., M.D., (Conservative Management of Periarthritis of the Shoulder) 376

Dillon, R. E., (An Emergency Air-Ground Transport System for the Newborn with Respiratory Distress Syndrome) .. 547

Dingley, A. F., Jr., M.D., (Conservative Management of Periarthritis of the Shoulder) 376

Drummy, W. W., M.D., (Mycoplasma Pneumoniae in Families—A Therapeutic Study) 1019

Dryden, Gale E., M.D., (Gastric Distension During Tracheoesophageal Fistula Repair) 46

Dyken, Mark L., M.D., (Principles of Therapy in Cerebral Vascular Disease) 898

Edmands, Robert E., M.D., (The Inotropic Effects of Digitalis: A Review) 268

Elliott, William C., M.D., (Carotid Sinus Nerve Stimulation in the Treatment of Angina Pectoris) 176

Farquhar, John S., M.D., (A Sign of Life on Indiana Highways) 480

Feigenbaum, Harvey, M.D., (The Graham Steell Murmur Mimicked by the Murmur of Mitral Stenosis) 165

Fisch, Charles, M.D., (Atropine in A-V Block) 367

Fisch, Charles, M.D., (Atropine in Myocardial Infarction) .. 1410

Fisch, Charles, M.D., (AV Dissociation: The Use of Isoproterenol (Isuprel®) 48

Fisch, Charles, M.D., (Digitalis Toxicity: A Review) 459

Fisch, Charles, M.D., (Pacemaker Electrocardiography)
Pt. 1 910
Pt. 2 1028
Pt. 3 1229
Pt. 4 1316

Fisch, Charles, M.D., (Q Waves in Idiopathic Hypertrophic Subaortic Stenosis) 808

Fisch, Charles, M.D., (The Graham Steell Murmur Mimicked by the Murmur of Mitral Stenosis) 165

Fisch, Charles, M.D., (The "Rule of Bigeminy") 172

Fontenot, Reed A., M.D., (Traumatic Arteriovenous Fistulae of the Kidney) 810

Gaver, Jessyca Russell (What Malpractice Suits are Doing to You, the Patient) 1417

Greenspan, Kalman, Ph.D., (The Inotropic Effects of Digitalis: A Review) 268

Helveston, Eugene M., M.D., (Current Legislation Proposals for the Multiple Handicapped Individual and the Indiana Physician) 35

Hickman, Jack W., M.D., (A Survey of Continuing Medical Education in Indiana) 29

Hickman, Jack W., M.D., (Son of Three-Legged Stool) 1237

Hickman, Jack W., M.D., (Three-Legged Stool Revisited) .. 1034

Higgins, James T., Jr., M.D., (Recognition and Management of Hypokalemia) 1299

Hill, Lloyd L., M.D., (Lounge Talk) 1419

Hill, Lloyd L., M.D., (New Monthly Feature) 1417

Jensen, K. E., Ph.D., (Mycoplasma Pneumoniae in Families—A Therapeutic Study) 1019

Johnson, Bendel, M.D., (Traumatic Arteriovenous Fistulae of the Kidney) 810

Kerr, John E., M.D., (Subglanular Urethral Fistula from Infant Circumcision) 130

King, Robert D., M.D., (Carotid Sinus Nerve Stimulation in the Treatment of Angina Pectoris) 17

Kissel, Wesley A., M.D., (Sedative Withdrawal Seizures) ... 79

Lackey, Jack T., M.D., (Subglanular Urethral Fistula from Infant Circumcision) 130

Lang, Erich K., M.D., (Aneurysms and Arteriovenous Fistulae in a Hypernephroma) 27

Lang, Erich K., M.D., (Arteriographic Assessment of Viability of Bowel after Perforating Abdominal Injury) 132

Lang, Erich K., M.D., (Arteriographic Diagnosis of a Bleeding Gastric Ulcer) 5

Lang, Erich K., M.D., (Arteriographic Diagnosis of Acute Pancreatitis) 121

Lang, Erich K., M.D., (Arteriographic Presentation of a Rhabdomyosarcoma of the Thigh) 46

Lang, Erich K., M.D., (Cerebellar Hemangioblastoma) 102

Lang, Erich K., M.D., (Sequestration of the Lung) 91

Lang, Erich K., M.D., (Traumatic Arteriovenous Fistulae of the Kidney) 81

Leamnson, George F., (Indiana Regional Medical Program) 133

Lenyo, L., M.D., (Mycoplasma Pneumoniae in Families—A Therapeutic Study) 101

Lieberman, Arnold, M.D., (The Case of the Rocky Ripples) 80

Linback, Richard E., M.D., (The Graham Steell Murmur Mimicked by the Murmur of Mitral Stenosis) 16

Lindseth, Richard E., M.D., (The Development and Treatment of Deformity in Pseudoachondroplastic Dwarfs) 122

Lloyd, Frederick A., M.D., (The Postoperative Use of Negative Suction in Urology) 25

Loh, Wei-Ping, M.D., (South American Medical Tour) ... 142

Long, Mary Tom, M.D., (An Emergency Air-Ground Transport System for the Newborn with Respiratory Distress Syndrome) 51

Lukemeyer, George T., M.D., (A Survey of Continuing Medical Education in Indiana) 2

McHenry, Paul L., M.D., (Carotid Sinus Nerve Stimulation in the Treatment of Angina Pectoris) 17

Mannion, Rodney A., M.D., (Subglanular Urethral Fistula from Infant Circumcision) 130

Mannion, Rodney A., M.D., (The Postoperative Use of Negative Suction in Urology) 25

Maxam, B. T., M.D., (Primary Malignant Tumor of the Jejunum) 139

Mericle, John E., A.B., (The "Rule of Bigeminy") 17

Iontgomery, Lall G., M.D., (Leiomyosarcoma of the Duodenum Treated by Pancreatoduodenectomy) 363

Iullins, Fitzhugh, M.D., (Methotrexate Therapy of Advanced Gastrointestinal Malignancy) 355

Iurray, Raymond H., M.D., (The Dangers of Dysbarism) .. 41

Jasser, William K., M.D., (The Graham Steell Murmur Mimicked by the Murmur of Mitral Stenosis) 165

Jay, Richard M., M.D., (Treatment of Congestive Heart Failure with Furosemide) 887

Iourse, Myron H., M.D., (Fistula Between Bowel and Urinary Tract) 1207

'enrod, Kenneth E., (Physician Manpower—"Telling It Like It Is") 905

'ittman, John, M.D., (The Cancer You View) 370

'opp, Richard L., M.D., (The Graham Steell Murmur Mimicked by the Murmur of Mitral Stenosis) 165

.ench, Mike, M.D., (Obturator Obstruction of the Intestine: Report of Two Unusual Cases) 1213

.ich, Richard B., M.D., (The Cryoextraction of Cataracts, A Comparative Study with Conventional Instruments) .. 801

.obinson, Robert D. Jr., M.D., (The Coronary Care Unit in a Small Hospital) 895

.oeske, Nancy A., M.D., (Current Legislation Proposals for the Multiple Handicapped Individual and the Indiana Physician) 35

.oss, Edward, M.D., (Carotid Sinus Nerve Stimulation in the Treatment of Angina Pectoris) 176

.owe, George A., M.D., (Stenosing Non-Peptic Esophagitis) 1404

t. Martin, Eugene, M.D., (Traumatic Arteriovenous Fistulae of the Kidney) 810

chmidt, Alden T., M.D., (Goodpasture's Syndrome in the Elderly, Report of a Case) 796

cully, W. E., M.D., (Mycoplasma Pneumoniae in Families—A Therapeutic Study) 1019

enterfit, L. B., Ph.D., (Mycoplasma Pneumoniae in Families—A Therapeutic Study) 1019

hah, Nalin G., M.B.B.S., B. Sc. (Medical), (Leiomyosarcoma of the Duodenum Treated by Pancreatoduodenectomy) 363

iderys, Harry, M.D., (The Cancer You View) 370

ternberg, Ella, M.D., (Goodpasture's Syndrome in the Elderly, Report of a Case) 796

terrett, William R., (Medicaid in Indiana) 920

terrett, William R., (Medicaid in Indiana) 1126

tone, John M., M.D., (Digitalis Toxicity: A Review) 459

Stonehill, Robert B., M.D., (A Survey of Continuing Medical Education in Indiana) 29

Stonehill, Robert B., M.D., (The Dangers of Dysbarism) .. 41

Tavel, Morton E., M.D., (The Graham Steell Murmur Mimicked by the Murmur of Mitral Stenosis) 165

Troy, Jack M., M.D., (Hypsarrhythmia Accompanying Tetany of the Newborn) 1216

Tupper, C. J., M.D., (County Medical Society—Scientific, Socio-Economic or Community Service—All These or Something Else?) 483

Turner, Raymond W., M.D., (Traumatic Arteriovenous Fistulae of the Kidney) 810

Ward, Will W., Jr., M.D., (Methotrexate Therapy of Advanced Gastrointestinal Malignancy) 355

Waymire, William M., M.D., (Stenosing Non-Peptic Esophagitis) 1404

West, R. F., M.D., (Mycoplasma Pneumoniae in Families—A Therapeutic Study) 1019

Young Alverson, Patricia, A.C.S.W., (Court-Ordered Contraception) 264

Young, Don J., M.D., (Court-Ordered Contraception) 264

Young, Honorable Don J., (Court-Ordered Contraception) .. 264

DEATHS

Armington, Robert L., M.D., Anderson 1272

Baker, Guy D., M.D., Crandall 860

Baldwin, John H., M.D., Jeffersonville 860

Bohner, Caryle B., M.D., Indianapolis (formerly) 217

Boyd, Stella, M.D., Evansville (formerly) 422

Brink, Calvin C., M.D., Gary 422

Buche, Frederick P., M.D., Richmond 974

Call, Herbert F., M.D., Indianapolis 1272

Congleton, George C., M.D., Terre Haute (formerly) 1453

Cooper, Harry L., M.D., South Bend 1164

Custer, Edward W., M.D., South Bend 1272

Donahue, Claude M., M.D., Carmel 860

Duckwall, Bertram, M.D., Terre Haute 974

Ehrich, William S., M.D., Evansville (formerly) 517

Fisher, Lawrence F., M.D., South Bend 974

Freeman, Leslie W., M.D., Indianapolis 974

Gammieri, Robert L., M.D., Indianapolis 1272

Gentile, John P., M.D., Jeffersonville 1453

Geyer, Joseph, M.D., New Albany (formerly) 422

Glendening, John L., M.D., Indianapolis 860

Hall, Orville A., M.D., Muncie 422
Harcourt, Allan K., M.D., Indianapolis 1272
Harrison, Benjamin L., M.D., New Castle 217
Hershey, Ernest A., M.D., Churubusco 422
Holmes, Phillip J., M.D., Madison 422
Holladay, Lloyd J., M.D., Lafayette 860
Hoyt, John M., M.D., Kokomo 974
Kammer, Walter F., M.D., Muncie 860
Kistner, Arthur W., M.D., Elkhart 517
Langohr, John L., M.D., Columbia City 1453
Leasure, John K., M.D., Indianapolis 974
Levin, Eli L., M.D., East Chicago 1272
Lewis, James F., M.D., Liberty 1453
McCallum, Joseph T. C., M.D., Indianapolis 217
McCormick, Hubert D., M.D., Vincennes 1453
McTurnan, Robert W., M.D., Indianapolis 1164
Marshall, Albert L., Jr., M.D., Indianapolis 217
Mertz, Henry O., M.D., Indianapolis 1453
Miller, Mahlon F., M.D., Fort Wayne 422
Mitchell, George L., M.D., Smithville 51
Nenneker, Henry, M.D., Evansville 21
Priebe, Fred H., M.D., Indianapolis 42
Rhodes, Theodore D., M.D., Indianapolis (formerly) 86
Robertson, Robert B., M.D., Indianapolis 116
Rogers, Arthur, M.D., Newburgh (formerly) 127
Sears, Murray M., M.D., Elkhart (formerly) 116
Singer, Elmer C., M.D., Fort Wayne 127
Somers, Gerald H., M.D., Fort Wayne 86
Stouder, Charles E., M.D., Ellettsville 42
Thompson, Alfred A., M.D., Tyner 97
Traver, Perry C., South Bend 21
Trontwine, William R., M.D., Crown Point 51
Vore, Hugh A., M.D., Warsaw 145
Wallace, H. C., M.D., Crawfordsville 116
Wiseheart, Robert H., M.D., Lebanon 86
Wooldridge, Omer, M.D., Columbus (formerly) 21
Worley, Ansel C., M.D., Fort Wayne (formerly) 51
Young, James W., M.D., Indianapolis 51

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